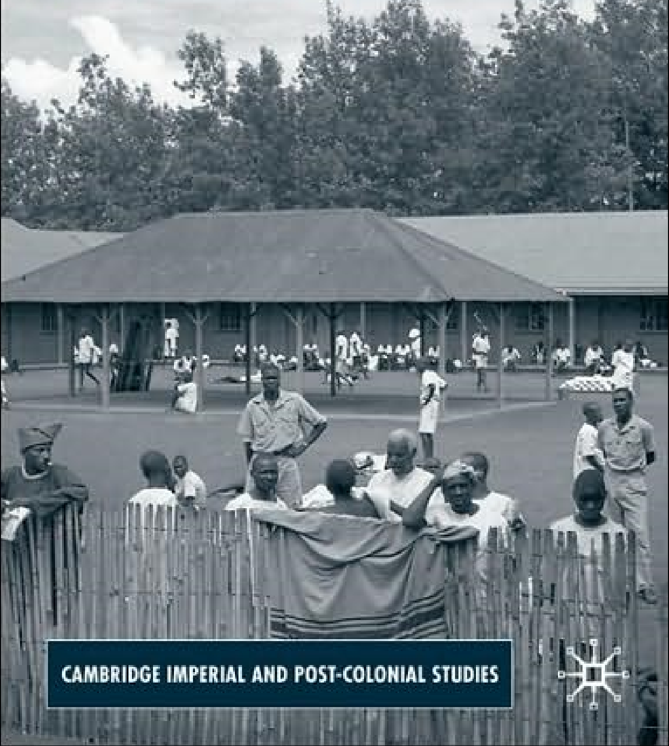
# Psychiatry and Empire

*Edited by*

SLOAN MAHONE *and* MEGAN VAUGHAN



CAMBRIDGE IMPERIAL AND POST-COLONIAL STUDIES

palgrave macmillan

# Psychiatry and Empire

Edited by

Sloan Mahone and Megan Vaughan

*Cambridge Imperial and Post-Colonial Studies Series*

General Editors: **Megan Vaughan**, Kings' College, Cambridge and **Richard Drayton**, Corpus Christi College, Cambridge

This informative series covers the broad span of modern imperial history while also exploring the recent developments in former colonial states where residues of empire can still be found. The books provide in-depth examinations of empires as competing and complementary power structures encouraging the reader to reconsider their understanding of international and world history during recent centuries.

*Titles include*:

Sunil S. Amrith
DECOLONIZING INTERNATIONAL HEALTH
India and Southeast Asia, 1930–65

Tony Ballantyne
ORIENTALISM AND RACE
Aryanism in the British Empire

Robert J. Blyth
THE EMPIRE OF THE RAJ
Eastern Africa and the Middle East, 1858–1947

Roy Bridges (*editor*)
IMPERIALISM, DECOLONIZATION AND AFRICA
Studies Presented to John Hargreaves

L.J. Butler
COPPER EMPIRE
Mining and the Colonial State in Northern Rhodesia, c.1930–64

T.J. Cribb (*editor*)
IMAGINED COMMONWEALTH
Cambridge Essays on Commonwealth and International Literature in English

Michael S. Dodson
ORIENTALISM, EMPIRE AND NATIONAL CULTURE
India, 1770–1880

Ronald Hyam
BRITAIN'S IMPERIAL CENTURY, 1815–1914
A Study of Empire and Expansion
Third Edition

Robin Jeffrey
POLITICS, WOMEN AND WELL-BEING
How Kerala became a 'Model'

Gerold Krozewski
MONEY AND THE END OF EMPIRE
British International Economic Policy and the Colonies, 1947–58

Sloan Mahone and Megan Vaughan (*editors*)
PSYCHIATRY AND EMPIRE

Javed Majeed
AUTOBIOGRAPHY, TRAVEL AND POST-NATIONAL IDENTITY

Francine McKenzie
REDEFINING THE BONDS OF COMMONWEALTH, 1939–1948
The Politics of Preference

John Singleton and Paul Robertson
ECONOMIC RELATIONS BETWEEN BRITAIN AND AUSTRALASIA, 1945–1970

Kim A. Wagner (*editor*)
THUGGEE
Banditry and the British in Early Nineteenth-Century India

**Cambridge Imperial and Post-Colonial Studies Series**
**Series Standing Order ISBN 0–333–91908–4 (Hardback) 0–333–91909–2 (Paperback)**
(*outside North America only*)

You can receive future titles in this series as they are published by placing a standing order. Please contact your bookseller or, in case of difficulty, write to us at the address below with your name and address, the title of the series and the ISBN quoted above.

Customer Services Department, Macmillan Distribution Ltd, Houndmills, Basingstoke, Hampshire RG21 6XS, England

# Psychiatry and Empire

Edited by

Sloan Mahone

and

Megan Vaughan

palgrave
macmillan

Editorial matter and selection © Sloan Mahone and Megan Vaughan 2007
All remaining chapters © their respective authors 2007

All rights reserved. No reproduction, copy or transmission of this publication may be made without written permission.

No paragraph of this publication may be reproduced, copied or transmitted save with written permission or in accordance with the provisions of the Copyright, Designs and Patents Act 1988, or under the terms of any licence permitting limited copying issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1T 4LP.

Any person who does any unauthorized act in relation to this publication may be liable to criminal prosecution and civil claims for damages.

The authors have asserted their rights to be identified as the authors of this work in accordance with the Copyright, Designs and Patents Act 1988.

First published 2007 by
PALGRAVE MACMILLAN
Houndmills, Basingstoke, Hampshire RG21 6XS and
175 Fifth Avenue, New York, N.Y. 10010
Companies and representatives throughout the world

PALGRAVE MACMILLAN is the global academic imprint of the Palgrave Macmillan division of St. Martin's Press, LLC and of Palgrave Macmillan Ltd. Macmillan® is a registered trademark in the United States, United Kingdom and other countries. Palgrave is a registered trademark in the European Union and other countries.

ISBN-13: 978–1–4039–4711–6 hardback
ISBN-10: 1–4039–4711–2 hardback

This book is printed on paper suitable for recycling and made from fully managed and sustained forest sources. Logging, pulping and manufacturing processes are expected to conform to the environmental regulations of the country of origin.

A catalogue record for this book is available from the British Library.

A catalogue record for this book is available from the Library of Congress.

10 9 8 7 6 5 4 3 2 1
16 15 14 13 12 11 10 09 08 07

Printed and bound in Great Britain by
Antony Rowe Ltd, Chippenham and Eastbourne

# Contents


*Acknowledgements* vii

*Notes on Contributors* viii

1 Introduction 1
*Megan Vaughan*

2 Taking Science to the Colonies: Psychiatric Innovation in France and North Africa 17
*Richard C. Keller*

3 East African Psychiatry and the Practical Problems of Empire 41
*Sloan Mahone*

4 The Microphysics of Power: Mental Nursing in South Africa in the First Half of the Twentieth Century 67
*Shula Marks*

5 Unsettled Minds: Gender and Settling Madness in Fiji 99
*Jacqueline Leckie*

6 The 'Godless' Freud and his Indian Friends: An Indian Agenda for Psychoanalysis 124
*Shruti Kapila*

7 Mapother of the Maudsley and Psychiatry at the End of the Raj 153
*James H. Mills and Sanjeev Jain*

8 The Nature of the Native Mind: Contested Views of Dutch Colonial Psychiatrists in the former Dutch East Indies 172
*Hans Pols*

9 Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry 197
*Alice Bullard*

10 Madness, Vice and Tabanka: Post-colonial Residues in Trinidadian Conceptualisations of Mental Illness 220
*Roland Littlewood*

*Index* 235

# Acknowledgements

The idea for this collected volume emerged out of the weekly seminar series run by the Wellcome Unit for the History of Medicine at Oxford University in the Spring of 2002. The theme 'Psychiatry and Empire' drew such strong interest and generated such lively debates that suggestions of an edited volume came from authors and audience members alike. Most of the original presenters appear in this volume, although in some cases their topics have shifted considerably. They are Shruti Kapila, Leslie Topp, James Mills, Roland Littlewood, Sloan Mahone, Richard Keller, Megan Vaughan, and Shula Marks. Since then we have welcomed the addition of Alice Bullard, Sanjeev Jain, Jacqueline Leckie, and Hans Pols. We would like to extend a special thanks to Mark Harrison, the Director of the Wellcome Unit in Oxford and to acknowledge the ongoing support of The Wellcome Trust.

# Notes on Contributors

**Alice Bullard** is Associate Professor in the School of History, Technology, and Society at Georgia Tech University, specializing in nineteenth and twentieth century francophone lands.

**Sanjeev Jain** teaches at the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India. In addition to being an active researcher exploring the molecular genetics of psychiatric and neurological disorders, he has been documenting the history of mental health services in India, from the colonial to the contemporary period. He has authored several papers, and edited an issue of the *International Review of Psychiatry* devoted to the history of psychiatry.

**Shruti Kapila** is University Lecturer in History at the University of Cambridge where she specializes in Modern South Asian history, the history of the British Empire and race and science. She is currently completing her book manuscript on the psychological sciences in Colonial India.

**Richard C. Keller** is Assistant Professor of Medical History and the History of Science at the University of Wisconsin-Madison. He is the author of *Colonial Madness: Psychiatry in French North Africa* (Chicago, 2007). He is currently working on a book documenting the institutional and ideological links between colonial medicine and the globalization of public health in the twentieth century.

**Jacqueline Leckie** is Senior Lecturer in Social Anthropology at the University of Otago, New Zealand. She has taught and published extensively on issues relating to ethnicity, gender, migration, mental health and work in the Pacific. She is the author of *To Labour with the State: The Fiji Public Service Association* and is completing two books: one on the history of Indians in New Zealand, and another on the history, institutionalism and construction of 'madness' in Fiji.

**Roland Littlewood** is Professor of Anthropology and Psychiatry at the Royal Free and at University College London. His publications include *Aliens and Alienists: Ethnic Minorities and Psychiatry* (with Maurice Lipsedge), *Pathologies of the West: The Social Anthropology of Psychiatric*

*Illness in Europe and America* and *Pathology and Identity: The Work of Mother Earth in Trinidad*. He is Past-President of the Royal Anthropological Institute.

**Sloan Mahone** is University Lecturer in the History of Medicine at Oxford University and Deputy Director of the Wellcome Unit for the History of Medicine, Oxford. She is currently revising a book manuscript on the nature of 'lunacy' in the tropics and is Director of a new research project on trauma and personhood in colonial Kenya.

**Shula Marks** is Emeritus Professor of History and Honorary Fellow of the School of Oriental and African Studies, a Distinguished Research Fellow of the School for Advanced Study of the University of London and a Fellow of the British Academy. Her publications include *'Not Either and Experimental Doll': the separate lives of three South African women*; *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* and *The Ambiguities of Dependence in South Africa: Class, Nationalism and the State in Twentieth Century Natal*.

**James H. Mills** is Director of the Centre for the Social History of Health and Healthcare (CSHHH) Glasgow, a research collaboration between the University of Strathclyde and Glasgow Caledonian University. His publications include *Cannabis Britannica: Empire, trade and prohibition, 1800–1928* and *Madness, Cannabis and Colonialism: The 'native-only' lunatic asylums of British India, 1857–1900*. He is Reviews Editor of the journal *Social History of Medicine*, an Editor of the journal *Social History of Alcohol and Drugs*, and a member of the editorial committee of the Drugs and Alcohol: Contested Histories series published by Northern Illinois University Press.

**Hans Pols** is the Director of the Unit for the History and Philosophy of Science at the University of Sydney. He has published on the history of the American mental hygiene movement, theories and treatments for war neurosis during World War II, and the history of medicine in the Dutch East Indies and Indonesia.

**Megan Vaughan** is Smuts Professor of Commonwealth History at Cambridge University. She is the author of *Creating the Creole Island: Slavery in Eighteenth-Century Mauritius*, *Cutting Down Trees: Gender, Nutrition, and Agricultural Change in the Northern Province of Zambia, 1890–1990* (with Henrietta L. Moore) and *Curing Their Ills: Colonial Power and African Illness*.

*This page intentionally left blank*

# 1
# Introduction

*Megan Vaughan*

> Madness is one of the ways in which man can lose his freedom . . . I can say that I have come to realise with horror how alienated the inhabitants of this country are. If psychiatry is a medical technique which aspires to allow man to cease being alienated from his environment, I owe it to myself to assert that the Arab, who is permanently alienated in his own country, lives in a state of absolute depersonalisation . . . The status of Algeria? Systematic dehumanisation.
>
> (Frantz Fanon, *Studies in a Dying Colonialism*)

For Frantz Fanon, the experience of colonial rule was the experience of a kind of madness. To be colonized was to be alienated from oneself and from one's environment, in just the same way as the person suffering from a psychiatric illness was said to be alienated from his or her self. For Fanon colonialism was synonymous with the violence of racism. Racism, he argued in *Black Skins, White Masks* and elsewhere, inflicted profound psychic damage, denying the colonized person the very possibility of subjectivity. Madness, in the old sense of 'alienation' was the result. Fanon was a practising psychiatrist, and his observations of his Algerian psychiatric patients were fundamental to his understanding of the workings of colonial rule more generally. For him there was a direct relationship between the generalized 'madness' of colonialism and the psychiatric disorders encountered in his practice.[1]

In the new and burgeoning literature on the history of psychiatry and empire, to which this volume contributes, we are continually returned to this theme: the analogy (or for some, homology) between the alleged madness of colonialism and the madness of the mad.[2] It was not only radical thinkers like Fanon who pointed to this relationship.

In different ways many politically conservative psychiatrists and psychologists working in imperial contexts often arrived at a similar analysis, though they drew different lessons from it. For them, the colonized subject was suffering from a profound maladjustment to the rapid exposure to modernity and 'civilization' which colonial rule presented. For this reason they too frequently turned their attention to the pathology of the 'normal' native's mind. For them, as for Fanon, there was an assumed two-way relationship between the manifestation of psychiatric disorders, as observed in colonial asylums, and the 'normal' native mind. To put it very briefly, in order to understand the nature of native psychiatric disorders (and in particular, to address the vexed question of whether such disorders fell into universal, cross-cultural categories) it was of course necessary to establish a baseline of normality. Was it 'normal', for example, for Africans to have visions, for Malays to suffer group hysteria, for colonized subjects more generally to be 'paranoid'? At the same time some speculated as to whether the articulations of the patients confined in colonial asylums could perhaps be read as saying something meaningful about the underlying causes of their pathologies. In this way some colonial psychological commentators did, in a sense, give madness a voice in their writings, arguing that a close reading of the content of delusions, for example, could provide clues to the underlying, structural causes of mental disorder.[3]

However, as many of the papers in this volume demonstrate, there is a wide and striking gap between the history of institutional psychiatric practice in colonial contexts in the nineteenth and twentieth centuries, and the intellectual history of an imperially-oriented psychiatry and psychology. Colonial psychiatrists come across as an ambitious group of professionals, even when (as was often the case) their formal qualifications did not match their ambitions. With some exceptions, it was not their objective to orchestrate a massive colonial 'Great Confinement', and even if they had such aims, most colonial states were too poor and too poorly organized to make such a thing achievable. Rather their ambitions lay in elaborating and promoting a psychological language with which to discuss the dilemmas faced by colonial administrations. Alongside the discipline of social anthropology, and sometimes in dialogue with it (Mahone in this volume), colonial psychiatrists offered an analysis of social evolution, and a scientific language in which to discuss a range of vexing behavioural traits amongst colonized peoples, from excessive docility to outright rebellion. Once we rid ourselves of the idea that colonial psychiatrists were engaged in a large-scale project of direct social control, a more nuanced and interesting history emerges. Their influence is less direct and more difficult to gauge, but they contributed

to and generated a number of discussions which are central to our understanding of the workings of colonial rule. Amongst these were the influence of 'race' on mind and behaviour, the question of cultural difference, the possibilities and limits of social transformation in the colonies, and the political evolution of colonial subjects. In some cases their colonial location gave them an unusual opportunity to extend their professional ambitions and placed them at the cutting edge of new technologies and treatments. More often conditions dictated that their psychiatric practice bore little or no relation to their professional and intellectual pretensions.

There is no one history of psychiatry and empire, as the papers in this volume clearly demonstrate. Despite some striking commonalities there are also marked differences between the ways in which the British, Dutch and French thought about the subject of their colonial subjects' minds. Even within one imperial context there could be marked variations between the theories and practices of psychiatrists in different territories. Most notably settler colonies tended to elaborate their own distinctive psycho-pathological discourses in which the language of 'race' showed itself to be remarkably resilient and adaptable. The ability of colonial subjects to answer back and write back to the theories expounded about them varied greatly and depended on levels of education and more generally on the degree of development of a local middle class. An Indian scientific elite engaged with, appropriated and critiqued Freud head-on in the early years of the twentieth century (Kapila in this volume); as colonial rule came to an end in West Africa in the late 1950s and early 1960s, a new generation of psychiatrists attempted to evolve institutions and practices which would be more culturally relevant, and less alienating, than the colonial asylums they had inherited.[4] It appears, however, that there is no clear break between the colonial and post-colonial histories of psychiatry. Psychiatric institutions in many parts of the post-colonial world remain chronically under-funded and under-staffed; questions about universality and cultural difference in relation to mental health continue to reverberate and reappear in metropolitan settings in the context of debates about immigration, and 'assimilation', and the hierarchies of the profession continue to exert an influence on how post-colonial psychiatrists position themselves on the 'culture' debate.

## Institutions

Much of the existing literature on psychiatry and empire concentrates on the history of institutions.[5] This may not only reflect on the influence of Michel Foucault on historians of colonialism, but also,

more prosaically it reflects the availability of historical documentation. Institutions leave records; the day-to-day struggles of communities to deal with the problems raised by mental illness generally do not. Recent work on 'lunatic asylums' in colonial Africa, by Sadowsky and Jackson, point to both the possibilities and the limitations of the institutional study.[6] Though the architecture, both physical and social, of these institutions is certainly revealing, Sadowsky and Jackson both also take us out of the confines of the building to trace the various paths taken by patients to the asylum, the legal frameworks in which they operated and more generally, the nature and preoccupations of the colonial states which they served. In general colonial psychiatric institutions only housed a fraction of those who might be understood by their communities (in very different and complex ways) to be mentally disturbed. Three papers in this volume focus on the quotidian reality of psychiatric institutions, and they all demonstrate that there is still much to be gained from the institutional approach.

Shula Marks' piece on the Valkenburg Asylum in Cape Colony, addresses a number of critical issues in the history of psychiatry in South Africa, in the period before the availability of psychotropic drugs everywhere transformed the running of psychiatric institutions. In particular, she draws our attention to a largely neglected, but very revealing aspect of this institutional story – that is the history of the subordinate staff on whom depended the day-to-day running of the asylum. Valkenburg was built in the mid-1890s, a purpose-built model institution designed from its beginnings to serve white patients only. Its pioneering Superintendent, William John Dodds, argued that the separation of white from non-white patients was essential if the stigma of mental illness was to be reduced. Race thus lay at the heart of a reforming agenda in the circumstances of late nineteenth century South Africa. Dodds' modernizing impulses also led him to set up a comprehensive record-keeping system, one which closely catalogued the age, marital status, religious affiliations and forms of mental disorder of his patients. The same record system paid almost as much attention to the staffing of the asylum as to its patients, and it is from this rich body of documentation that Marks tells a very revealing story. According to the reformist racial thinking of the day, white patients required white staff to serve them, but finding willing and suitable recruits was not easy. The vast majority of nurses and attendants (many of whom were recruited from Europe) were of working class or lower-middle class origins, had minimal education, and were frequently accused of

insubordination, acts of violence towards inmates, desertion and generally of not being of 'the right sort'. That they deserted in such large numbers is hardly surprising given the appalling conditions in which they lived and worked, their low wages, restrictions on their personal lives, and the generally low status attached to their work. In turn, it seems, they frequently vented their frustrations in acts of violence and cruelty towards their patients. Violence in the asylum, Marks argues, was no 'momentary aberration', but rather an illustration of the 'microphysics of power'. If conditions in the model white institution were bad, we must assume that they were even worse in those designed for black patients. Violence is perhaps a feature of all closed institutions, but as Marks shows, race, gender and class divisions combined in different ways in South Africa to give that violence a particular and historically specific character.

In her piece on the history of the St Giles asylum in Fiji, Jacqueline Leckie also draws attention to the day-to-day running of a colonial asylum, which paid as much attention to the bodily management of its inmates as it did to their minds. There were probably very good reasons for this. The appallingly high mortality rates (in the period 1884–1933 this ran at around 47 per cent of admissions) may have reflected poor conditions in the asylum, but there are indications that many patients were already suffering from serious organic illnesses when admitted. As elsewhere in the colonial world, and much to the chagrin of professional psychiatrists, the asylum often became the repository of the destitute and chronically ill. The main focus of Leckie's paper, however, is on the gendered and embodied nature of madness as it was constructed and treated within the Fijian institution. Prominent amongst the female patients of St Giles were those suffering from what would now be diagnosed as post-partum psychosis. But even beyond these cases, madness amongst women was closely related to their sexuality and to their reproductive functions. Though Leckie sees gender as the central organizing principle of the asylum, she also makes clear that ethnicity (and to a lesser degree, class) were central to the delineation of mad behaviour. The political economy of Fiji, its experience of Indian indentured labour, the plantation economy, and the fate of indigenous Fijians are all reflected in the records of the asylum.

It seems clear that many, if not most, colonial asylums in the second half of the nineteenth century were over-crowded and neglected, and despite the efforts of some reformers, resembled prisons rather than hospitals. In these respects they were not radically different to their

metropolitan equivalents, but with even poorer standards of provision and higher mortality rates. But as James Mills and Sanjeev Jain show, this picture of neglect was not confined to the nineteenth century. On the eve of the Second World War, Edward Mapother, Medical Superintendent of the Maudsley Hospital in London, toured the psychiatric hospitals of Ceylon and India. His highly critical reports indicated that on the eve of decolonization in South Asia, mental health was still neglected, both in terms of institutional provision and in terms of the training of doctors and nurses. Ceylon compared unfavourably with India, but provision in India varied widely from place to place and much of it was inadequate. Amongst Mapother's criticisms of some of the Indian staff he encountered was their 'devotion' to psychoanalysis, at the expense of psychiatry. Overall, though, the central problem was one of funding and lack of provision, as Mapother made abundantly clear with his calculations: 'the death rate of the mental hospitals', he argued, 'is in proportion to their cheapness.' Mapother may have had ambitions for a thorough-going reform of South Asian psychiatric services, such as he had pushed through in London, but the political will was not there and the funds were not available. Others, however, had greater opportunities to put their ideas into practice.

## Ambitions

As psychotropic drugs became available in the second half of the twentieth century, and some mental illnesses became more immediately treatable, so the regimes of colonial psychiatric institutions shifted along with those of their metropolitan counterparts, allowing, amongst other things, a higher rate of patient turnover. Yet even before the advent of more effective drug regimes, the French psychiatrists practising in North African institutions, whose history is recounted here by Richard Keller, were determined, not only to reform the treatment of the mentally ill, but to effect cures. The story of the 'Algiers School', as it came to be known, stands in stark contrast to the more general pattern of impoverished colonial institutions, and frustrated professionals reduced to the equivalent of prison warders. This is a complex and fascinating story of the relationship between science and imperialism. Between 1911 and 1954 the Algiers School embarked on a programme of radical institutional reform and codified ideas about the relationship between ethnicity and psychopathology. Their ambitions were both institutional and intellectual, and they effectively shifted the centre

of gravity of the French psychiatric profession to the colonial setting of North Africa. As Keller argues, there is an apparent paradox in this history:

> '.... exploring the Algiers' School's obsession with innovation exposes the paradox of how a violent, uncomprehending, racist organisation could simultaneously be a responsive nuanced medical circle, that positioned itself at the cutting edge of medical science.' (Keller p. 18 in manuscript)

Capitalizing on the relative autonomy they enjoyed in the North African colonies, reforming psychiatrists had as early as 1911 established an 'open' psychiatric service in Tunis. By the 1930s North African psychiatric institutions, with their dispensaries and social services units, could be held up as showcases 'not only for colonial beneficence, but also for the advance of the psychiatric profession.' But the ambitions of these professionals did not stop there. Their extensive contact with North African patients gave them the 'raw material' with which to elaborate new and influential theories on the effects of 'race' and Islamic culture, not only on the psychopathology of their patients, but also on the 'normal' psychology of the North African. As in British East Africa (see Mahone in this volume), so in the French North African colonies psychiatrists argued that colonial subjects were 'essentially abnormal' in their normal psychological state. If both 'tribe' and 'detribalisation' were responsible for this in East Africa, in North Africa Islam was the major culprit. This was not simply seen as a cultural influence, it was a cultural influence which allegedly had measurable effects on brain structure. Keller demonstrates that this was a pioneering, innovative group of professionals, breaking new ground in the treatment of psychiatric patients, but they were hardly immune from the politics of the settler societies in which they were located. In their writings they forged a link between the behaviour of their sometimes violent, criminally insane patients and Islamic cultural traditions, through the supposedly definitive evidence of brain structure. As Keller argues, this is a more complex story than simply one of the psychiatric profession acting in defence of a racist colonial administration. Nevertheless, there is more than an echo of Fanon here. If their early twentieth century reforms had given these psychiatrists the opportunity to promote the idea that mental illness was curable, they also allowed them an unusually large degree of autonomy and access to a patient population. Eager to pioneer the latest therapies, by the 1940s and 1950s they enthusiastically adopted

both electroconvulsive therapy and psychosurgery, to a degree only possible it seems in a colonial setting and which can only be interpreted as abusive.

If the 'Algiers School' has been accused of employing psychiatrists in the service of colonial racism, so too have the members of the 'East African School' discussed by Sloan Mahone. Like their North African counterparts, the colonial psychiatrists of the British East African colonies were partial to a bit of psychosurgery, though they never got to practice it on any large scale. But like Keller, Mahone argues that the history of this group and the institutions they worked in is more complex than the existing literature on them would allow.[7] Though some of the East African 'mental specialists' had little or no formal training, and though they can hardly be regarded as equivalent in their influence to the members of the 'Algiers School', as Mahone shows, their work needs to be taken more seriously than it has been hitherto. Their influence on late colonial thinking, though impossible to gauge accurately, appears to have been significant. As in so many other cases, this influence was felt through their speculations, not so much on the psychopathology of their patients as on their theories of the 'abnormal' state of the 'normal' natives' mind, made more vulnerable by the demands of 'culture contact', which was short-hand in East Africa for the far-reaching disruptive and sometimes violent effects of settler colonialism. Mahone argues that the influence of psychiatric ideas in colonial East Africa is to be found outside the immediate medical domain, in the production and dissemination of a psychological terminology with which to discuss some of the pressing problems faced by the late colonial administration. Alongside another influential discipline, social anthropology, the psychiatrists were involved in elaborating theories of 'acculturation', 'culture contact' and the vexed issue of the 'educability' of the African. All of these theories had important political consequences for they bore directly on the question of whether and when increasingly 'detribalised' Africans would ever be ready to govern themselves. The answers to this last question were largely negative. To anthropological theories of systems breakdown, psychiatry added its own language of the disintegration of the African personality and the profoundly damaging effects on the psyche of an advancing and alien individualism. In her paper Mahone argues that the attention paid to the East African School's more blatantly racial theories of the 'African mind' may have detracted from a more pervasive influence in contributing to an intellectual rationale for colonial rule.

The 'Dakar School' (described here by Alice Bullard) which emerged in the early 1960s, as the French West African territories achieved their independence, was an ambitious attempt to reform the practice of psychiatry and to move beyond its colonial heritage. Initiated by Henri Collomb, a Belgian military doctor paid by the French state, the Fann psychiatric hospital, housed at the University of Dakar, championed a form of 'transcultural psychiatry' which included the integration of African traditional healers into its day-to-day practice and an 'open door' policy which reflected what Collomb saw to be an African tolerance and acceptance of 'madness'.[8] The reformist ambitions of Collomb and his colleagues may have drawn on the slightly earlier initiatives of the Nigerian psychiatrist, T. A. Lambo, who had developed a village model in his practice and had also advocated cooperation with local healers.[9]

Impressive as these innovations were, as Bullard shows, the practice of 'transcultural psychiatry' was not without its complications, and some notable post-colonial ironies. The Senegalese psychiatrists and nurses who took over from Collomb and his French colleagues in the late 1970s were deeply ambivalent about Collomb's collaboration with traditional healers and wary of delving into the spirit world. French doctors might do this with immunity to both themselves and their professional reputations, but it was not so straightforward for the Senegalese professionals.

One common thread running through these very different colonial and post-colonial psychiatric projects was the role and significance of 'culture'. In some colonial psychiatric theories 'culture' (and in some circumstances, religion) was merely a more acceptable term for 'race'. In other cases, however, psychiatrists and psychologists were genuinely grappling with difficult questions in what came to be known as 'cross-cultural' psychiatry. How universal were categories of mental illness? How did different cultural traditions deal with these problems? What influence should cultural practice have on diagnosis and treatment? In the context of colonial rule (and indeed of post-colonial metropolitan debates on immigration) was it possible to argue for cultural difference, without being read as arguing for racial difference?

## Culture, race and governance

A number of contributors to this volume are keen to stress that the history of psychiatry and empire is more complex and more subtle than one which sees psychiatry simply as a tool of colonial racist oppression. Such an account both over-estimates the power of psychiatrists in imperial contexts and under-estimates the complicated relationship

between scientific knowledge and power. But the strange career of 'race', sometimes dressed up as 'culture', is certainly present in many of these accounts, particularly those which refer to colonies of white settlement. Equally evident is the relationship between psychological theories and the problems of governance in the context of the evolution of colonial nationalism.

The innovative and ambitious reformist twentieth-century psychiatrists of the Algiers School, analyzed by Richard Keller, saw themselves as part of a longer-term French 'civilising mission', one which applied the modern tools of science to the problem of mental illness. Their extensive contact with North African patients provided them with an evidential basis on which to confirm some common-sense settler suspicions, not only on the nature of 'Muslim madness', but also, more invidiously, on the pathological nature of the 'normal' North African mind. Reformist cutting-edge in their practice, their theories nevertheless lent scientific credibility to the idea that biological difference was at the heart of the problem of psychopathology in the North Africa. Their accounts extended the common settler notion of Arab fatalism by locating the effects of Islamic cultural traditions on brain structure.

Colonial psychiatrists in the twentieth century worked in a changing political context in which questions of governance and resistance were unavoidable. In the first two decades of the twentieth century the Dutch in the East Indies had promoted an 'ethical policy' which, in addition to its welfarist aims, included the establishment of a popular assembly. By the 1920s, however, the growth of nationalist sentiment amongst their colonial subjects had produced in the Dutch a reactionary response. Amongst the arguments advanced for implementation of repressive political measures, was a psychological one. The Indonesian people, argued the psychiatrist Travaglino (drawing on Kraepelin's theories), showed an unusual sensitivity to emotions. Extending his observations of psychiatric patients to the population as a whole, Traviglino argued that Indonesians were like infants, ruled by their desires, with an underdeveloped sense of social responsibility. It followed that they were extremely vulnerable to being misled by radical elements and needed strong guidance from their colonial overlords. Though Traviglino also argued that 'Eastern' culture was not inferior, just different, the political lessons of his scientific observations were only too clear, and, argues Pols, this psychological discourse on the nature of the 'native mind' became commonplace in the Dutch East Indies in this period.

Echoes of this story can be found in other parts of the colonized world in the twentieth century. Although the precise formulations

varied from context to context (Malays were 'over-emotional', North African Muslims had their brains turned by Islam, 'detribalization' was sending East Africans mad), the common thread of these psychological theories, propounded by psychiatrists, was that there was something abnormal about the 'normal' native mind. Such a theory cast serious doubt on the advisability of moving colonized people towards self-government and it pathologized political activists, who could be viewed, either as suffering more extreme forms of the 'normal' pathologies of their people, or as cynical manipulators of infantile and vulnerable minds. In British East Africa in the inter-war period, for example, psychiatrists of the 'East African School' addressed themselves to the perceived problem of 'detribalization' or 'acculturation' as some preferred to call it. They were not alone in this intellectual focus – social anthropologists were also concerned with what they frequently saw as a 'systems breakdown' in the face of the far-reaching economic, social and cultural changes of colonial rule. While anthropologists concentrated on changes at the level of 'tribal' entities, psychiatrists offered a distinct medico-psychological approach which located the detrimental effects of 'culture contact' in the individual African's personality and psyche. This approach, argues Mahone, can be traced in a range of official documents addressing the problems of 'individualism' and the 'educability' of Africans and their capacity for self-government. While much attention has previously been paid to the East African psychiatrists' more explicitly racist statements on the African mind and their physical measurements of brains, Mahone argues that it is in the formulation and promotion of this useful medico-psychological discourse that we can trace the real influence of colonial psychiatry on late colonial thinking and policy in East Africa.

## Answering back

As a political activist, Fanon famously answered back at the pseudo-theories of his fellow psychiatrists. In his formulation, it was not the natives who were mad, it was the colonial system, the racist violence of which denied colonized people the very possibility of subjectivity. Angrily responding to Mannoni's psychoanalytic account of colonial dependency, Fanon attempted to de-pathologize colonial resistance and rebellion.[10] Others were also answering back, in different ways, sometimes anticipating Fanon's attack. In the Dutch East Indies a group of Indonesian physicians in the 1920s launched a sustained critique

on what they termed the 'psychiatric fascism' of colonial psychiatrists' accounts of the native mind. They did so, not by denouncing the project of developing a psychology of the Indonesian people, but rather by attacking the poor scientific standards of their Dutch colleagues. Undermining the premise of much colonial psychological thinking, they argued that no credible account of the 'normal' mind could be constructed from data derived from studies of the mentally ill. Any study of the Indonesian psyche would have to be conducted using the strictest scientific methods. Amongst other things, it followed that the researchers would need to be fluent in the local language and alert to the nuances of local culture – in short, only indigenous physicians like themselves were properly qualified to carry out such a study.

In India a local intelligentsia had been answering back since the at least the turn of the century, as Shruti Kapila shows in her account of the Indian appropriation of Freud's theories. For some members of the Indian scientific and intellectual elite, psychoanalysis provided a useful language with which to discuss the modern condition. As Kapila makes clear, these Indian intellectuals were not simply responding to Freud, they were challenging and appropriating his theories with a marked degree of confidence. Girindrashekhar Bose, sometimes referred to as the 'Indian Freud', had a correspondence with Freud lasting 11 years, in the course of which he critiqued Freud's notion of repression and the cultural limitations of his theory of the Oedipal complex. But it was on the question of religion and its place in psychoanalytic theory that Bose and his colleagues engaged most actively. Searching for their own explanations of the modern condition and of the place of religion within this, Freud's Indian interlocutors questioned the relationship he had attempted to establish between religion, neurosis and the 'primitive'. For Bose and others, religion was to be seen as a palliative for human suffering, not as an obsessive collective neurosis. There were other, more productive ways, they argued, to explore the psychoanalytic content of religious beliefs, and for them the opposition set up by Freud between science and religion was a non-question. By the 1920s, then, Freud had entered the vocabulary of a small but influential group of Indian intellectuals as they grappled with the major issues of the day, but it was in challenging some of the fundamentals of Freudian theory, rather than accepting them as universal truths, that this vocabulary acquired its relevance and meaning.

The connections between this lively intellectual engagement with psychoanalysis and the institutional practice of psychiatry in colonial India are extremely tenuous, as Kapila points out. Psychoanalysis was a

theory which apparently broke down the distinction between 'normal' and 'abnormal', but Freud's homologous relationship between the 'primitive' and forms of infantile neurosis could not be innocent in a colonized world, and there were echoes of it in the attempts of colonial psychiatrists to pathologize the behaviour of the 'normal' native. Indian intellectuals answered Freud back on this point, but there was no necessary connection between this engagement and the treatment of 'true' deviants, the inhabitants of India's asylums.

The relationship between science (in the form of psychology) and religion, which was at the heart of the Indian engagement with Freud, was played out in different ways in different political and institutional circumstances. Local intellectuals did not always champion assumed 'indigenous' values. In late colonial Senegal, French psychoanalytically-informed psychiatrists working in the Fann clinic committed themselves to a dialogue, which sometimes amounted to an attempted incorporation, of local spiritual beliefs and practices. Their project of 'transcultural psychiatry' won praise from independent Senegal's first president, Léopold Senghor, for utilizing the methods of 'Black Africa'. In the 1970s, the WHO and other international organizations also began to take an interest in African 'traditional' healing practices, contributing to a programme of certification and formalization – in short, a process of professionalization. When, in the late 1970s, the French psychiatrists at Fann were replaced by Senegalese and other West African professionals, there was something of a backlash against 'transcultural psychiatry' and particularly its engagement with the spiritual world of Senegalese patients. As Bullard writes, the African doctors and nurses occupied a different 'professional space' to that of their European predecessors:

> The French researchers were labouring under the weight of colonial racism, and trying to approach Senegalese cultures with open, appreciative minds. The Senegalese doctors and nurses face the task of assuming the status of 'scientist' and of embodying the authority of medical science over and against the authority of healers. In this they are working through an Oedipal drama writ large. (Bullard, p. 210)

This volume does not aim to outline a history of madness and empire – a much larger and ambitious task. However, Roland Littlewood's chapter in this volume is a reminder that beyond the theoretical discussions and ambitions of colonial psychiatrists, and beyond the institutions which they helped define and run, there lies another history. In his

account of conceptualizations of mental illness in post-colonial Trinidad, Roland Littlewood disputes the idea that colonial psychiatrists and their institutions had any far-reaching effects at all. They may be held responsible for segregated facilities, for prejudice and neglect, 'but hardly practicable ideologies for racial or cultural inferiority.' (Littlewood, p. 220). What Littlewood does document, however, is what he calls the 'post-colonial residues' in conceptualizations and expressions of mental illness in Trinidad in the 1980s and 1990s. Race, gender, class, and particular post-colonial notions of respectability and reputation, are all present in the local categories of madness. The madman in Trinidad is figured as characteristically male. He may be suffering from *studiation*, that excessive mental absorption in either science or sorcery, which leads to social withdrawal. Excessive study is one of its causes, and implicit in this is a critique of those who place too much emphasis on individual academic achievement, at the expense of community solidarity. Or he may be suffering from *tabanka*, the terrible grinding worry which afflicts men of the *petit bourgeoisie* when they experience the humiliation of their wives leaving them, or some other blow to their reputation. 'With tabanka', writes Littlewood, 'a man is caught short, without either reputation or respectability. His mistake is infatuation with a wife and with White values, a failure to perceive his real interests and maintain his autonomy.' Even apparently random eruptions of madness do not escape social meaning, in Trinidad as elsewhere, but these apparently 'indigenous' explanations are not independent of external influence and of a particular history. They are rooted, argues Littlewood, '. . . in the colonial and economic history of the West Indies, in the inescapable irony of being poised between two ascribed sets of values, one derided as worthless, the other precariously attainable.' (Littlewood, p. 233).

Littlewood's paper is a reminder to us that the historical experiences of slavery and colonialism have, in some circumstances, had profound effects on the ways in which communities and individuals assign meaning to their actions, and in his account there is more than an echo of Fanon. In their painful experiences, sufferers from *tabanka* and *studiation*, provide what Littlewood calls 'ironic commentaries' on colonial and European values, and those who seek to live by them.

As many papers to this volume are at pains to emphasize, we should not over-estimate the role played by professional psychiatry in the history of modern imperial projects of social and political control. If the influence of the scientific discipline of psychiatry was frequently indirect, it was nevertheless revealing of the contradictions

and dilemmas faced by colonial authorities. Colonial psychiatrists and psychologists purported to have access to the inner lives of colonial subjects, to have explanations for their behaviour and persuasive accounts of their motivations. The language of the psyche was and is a powerful one, whether it is wielded by professional psychiatrists, or by local communities defining who is, and who is not, behaving according to accepted norms. It is also a language which can be used for a range of political purposes. Colonial psychiatrists often (but not always) used it to define the normal native as abnormal – a rather alarming notion, but one which had some political utility when colonial nationalism appeared to be running out of control. Fanon, trained in the same language, used it powerfully to call for violent resistance against colonial oppression.

## Notes

1. Francoise Vergès, 'Chains of madness, chains of colonialism: Fanon and freedom', in Alan Read (ed.), *The Fact of Blackness: Frantz Fanon and Visual Representation* (London: 1996), pp. 46–76.
2. Richard Keller, a contributor to this volume, has written a comprehensive survey of the literature on psychiatry in the British and French empires: 'Madness and colonization: psychiatry in the British and French empires, 1800–1962', *Journal of Social History*, 35 (2001) 295–326. Jock McCulloch surveyed the literature on Africa in *Colonial Psychiatry and the 'African Mind'* (Cambridge: 1995) and R. Collignon produced a review of the history of French colonial psychiatry in 'Pour une histoire de la psychiatrie coloniale française', *L'Autre: Cliniques, cultures et societés*, 3, 3 (2002) 455–80. See also Robert Bethelier, *L'Homme Maghrebian dans La Littérature Psychiatrique* (Paris: 1994).
3. Megan Vaughan, 'Idioms of madness: Zomba lunatic asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies*, 9 (1983) 218–326.
4. See Bullard in this volume and Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: 1999) for the work of T. A. Lambo in Nigeria.
5. Amongst the early institutional studies are Waltraud Ernst's pioneering work on the European insane in colonial India, *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (New York: 1991) and my own brief exploration of the history of the colonial lunatic asylum in the British Central African colony of Nyasaland: Vaughan, 'Idioms of madness'. More recently there has been a wave of institutional studies including James Mills, *Madness, Cannabis and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857–1900* (Basingstoke: 2000); Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: 1999); Lynette Jackson, *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe, 1908–1968* (New York: 2005). For more references to the growing literature on colonial Africa see Shula Marks' piece in this volume.

6. Sadowsky, *Imperial Bedlam*; Jackson, *Surfacing Up*.
7. This literature includes the widely-cited work of McCulloch, *Colonial Psychiatry*.
8. On the Fann Clinic see also René Collignon, 'Santé mentale entre psychiatrie contemporaine et practique traditionelle, (Le cas du Sénégal)'. *Psychopathologie Africaine*, 30, 3 (2000) 283–98.
9. T. A. Lambo, *African Traditional Beliefs: Concepts of Health and Medical Practice* (Ibadan: 1963). Lambo's work is also discussed in Sadowsky, *Imperial Bedlam*.
10. Frantz Fanon, *Black Skins, White Masks*, translated by Charles Lam Markmann (London: 1996).

# 2

# Taking Science to the Colonies: Psychiatric Innovation in France and North Africa

*Richard C. Keller*

Historians have in recent years increasingly questioned standard assumptions about the relationship between science and imperialism. For decades, scholars characterized colonial scientific development as following an established pattern of gradual diffusion as knowledge and innovation moved outward from Europe to the margins of empire.[1] By these accounts, activity at the periphery consisted of simple data-gathering and specimen-collection, dependent upon and derivative from the center, where prestigious institutions, associations, and organizations confirmed findings and generated conclusions. By the same token, the only legitimate scientific pathway from colony to colony passed through metropolitan sites like London, Paris, and Amsterdam, hubs for the dissemination of imperial knowledge. Yet scholars from a range of disciplines now see a more complex interaction unfolding under imperialism. The entrepreneurial spirit of many settler scientists, the uses of science and technology in the ideological defense of domination, and the lack of professional scrutiny in many colonial settings created unique opportunities for experimentation and innovation.[2] According to much of this work, overseas territories served as vast laboratories for testing and perfecting a range of medical, scientific, and social projects before their implementation in European settings.[3]

In the history of psychiatry, however, the notion of productive cores and stultified peripheries has proven resilient. Such arguments appear to hold for the British case: with some notable exceptions, isolated physicians in Nigeria, in East Africa, and even in India with little or no psychiatric training offered at-best custodial care for the insane and produced little durable research in the process.[4] In the French case – at least before the twentieth century – psychiatry was also largely a metropolitan affair. Whether one dates the origins of the French profession to Louis XIV's

creation of the Hôpital Général in 1656, to Philippe Pinel's legendary (if apocryphal) liberation of the insane at Bicêtre during the Revolution, or to the Law of 1838 that regulated the internment of lunatics, change radiates outward from a Parisian hub.[5]

Yet if one considers the development of French psychiatry in the twentieth century, a different trajectory appears. Pioneers in the United States and in several European locations outside of France developed most of the discipline's novel concepts between 1900 and 1950. Yet curiously, such ideas crossed the Mediterranean to the French colonies in Algeria, Tunisia, and Morocco as easily as they crossed France's European borders. In North Africa, members of the Algiers School of French psychiatry implemented these technologies at least contemporaneously with – and in many cases far earlier than – their metropolitan colleagues. Founded at the Algiers medical faculty by Professor Antoine Porot in 1925, the School is best-known as the target of Frantz Fanon's outrage in *The Wretched of the Earth*.[6] Fanon indicted these psychiatrists' deployment of spurious data to produce a collective diagnosis of the North African mind as primitive, criminally impulsive, and intellectually feeble. Historians have since considered the Algiers School as little more than a pseudo-scientific support system for colonial racism.[7]

Fanon's assessment is a valid one: practitioners like Porot and his students often defended colonial interests above those of their patients. But the Algiers School also presents the researcher with significant complexities that undermine a dismissive condemnation. Between 1911 – when Porot founded the first psychiatric clinic in North Africa – and the outbreak of the Algerian war in 1954, members of the School implemented radically new institutional designs, codified ideas about the relationship between ethnicity and psychopathology, and pushed the limits of experimental treatments. Psychiatry's revolutions in social engineering and therapeutics were in many cases extensively deployed in North Africa before they made a dent in metropolitan French practices. The Algiers School came into existence during a crisis in French psychiatry, and was uniquely positioned to take advantage of this crisis and of the political culture of French colonial medicine after the World War I. Exploring the Algiers School's obsession with innovation exposes the paradox of how a violent, uncomprehending, racist organism could simultaneously be a responsive, nuanced medical circle that positioned itself at the cutting edge of mental science.

From their very origins, the psychiatric institutions of French North Africa attempted to rejuvenate the profession through humanitarian and scientific innovation. Although the French presence in the Maghreb

dates to the 1830 conquest of Algiers – solidified with the proclamation of Algeria as three French departments in 1848 and with the addition of protectorates in Tunisia (1881) and Morocco (1912) – concern for the insane began in earnest at the turn of the twentieth century. Physicians pressed colonial administrators to reform care for the mentally ill in North Africa, pointing to horrid situations in which many patients were chained night and day, abandoned to languish in their own filth.[8] The situation was so egregious that the Congress of French and Francophone Alienists and Neurologists, a powerful professional organization, held its 1912 meeting in Tunis to call attention to the problem. Arguing that colonialism 'created not only rights, but also imperative duties,' reformers struggled to place mental assistance on legislative agendas throughout the Maghreb. Modern psychiatric institutions, they argued, would demonstrate a commitment to 'civilizing' what many French physicians and administrators considered to be a barbaric domain.[9]

A glimpse at the situation of the psychiatric profession in early twentieth-century France illustrates the significance of the discipline's expansion into the colonies. By many accounts, French psychiatrists in 1900 found themselves under siege. They had achieved significant influence on the continent by the 1870s, but soon faced challenges on a number of fronts. To make matters worse, most of these challenges came from German-speaking territories in the aftermath of France's humiliating rout in the Franco-Prussian war. Emil Kraepelin's new classification of mental disorders, for example, overthrew Morel's notion of a hereditary–degenerative disease continuum. Likewise, Freudian psychoanalysis revolutionized the doctor–patient relationship as well as prevailing ideas about the etiology of mental illness, challenging the organic model of psychosis that remained so influential in French circles. Complicating the problem in France, psychologists and philosophers like Pierre Janet and Henri Bergson increasingly encroached onto psychiatric ground, and French mental health's greatest luminary, Jean-Martin Charcot, was a neurologist rather than an alienist, prompting vicious boundary disputes.[10] All the while, psychiatrists remained invested in an outdated asylum system that had set their professional course decades earlier.

Conscious of the calamitous state of their discipline, reform-minded psychiatrists in France began to call their profession's most basic practices into question. The early twentieth century was a transitional moment for therapeutics in much of Europe and the United States. In addition to the development of psychoanalysis, mental hygiene and psychiatric outreach into schools, prisons, and workplaces appeared

as promising alternatives to the longstanding practice of segregating the mentally ill from society in private or public facilities. Citing the efforts of a range of mental hygienists in the United States and Europe, the psychiatrists Edouard Toulouse, Georges Génil-Perrin, and Roger Dupouy founded the Mental Hygiene and Prophylaxis League in 1922 with the goal of reforming the 1838 law. The law had been novel for its era – predating English or American legislation – and provided comprehensive guidelines for psychiatric internment and patients' rights. But such legislation proved overly rigid in practice. Medical decisions rested in the hands of the prefectures, and confinement tarnished even the mildly ill with the stigma of lunacy. These clear lines between madness and reason represented an obsolete code for patient care. In the asylum's stead, triage, the early treatment of acute disorders, and short-term hospitalization encouraged a more flexible conception of pathology and rehabilitation, and could in turn greatly reduce the need for long-term confinement. The results of early trials suggested to Toulouse that 'madness, in a great number of cases, was avoidable and curable,' and that decisive action could 'prevent acute afflictions from becoming chronic.'[11]

The League proposed a transition from the lunatic asylum to the psychiatric hospital, with an emphasis on prophylaxis and an organized division of labor. The psychiatric hospital held the potential to stamp out the plague of mental illness through what Toulouse called a 'biocracy,' where 'social evolution would be directed by the life sciences.'[12] A bill the League submitted to the French Senate in 1923 outlined a program for 'open services' that could avoid the asylum system's worst abuses.[13] A dispensary to perform triage and outpatient treatment, sending some patients to the psychiatric hospital for more sustained observation; social services to extend the dispensary's reach into the public through surveillance of patients' homes, schools, workplaces, and homeless shelters; and laboratories and research centers to provide scientific backing to clinical diagnoses were just some of the revisions they proposed.[14]

Such programs had already proven their merit not only in a number of European and American cities, but also in French North Africa. Advocates for the system pointed to the 'open psychiatric service' founded in 1911 at the French public hospital in Tunis by Dr Antoine Porot. As the 1838 law had not been promulgated in Tunisia, the clinic, which served Tunis's European community, was free to operate outside its purview. Porot had 'reduced the formalities of entry to a minimum' by cutting police and judicial authorities out of the process. The resulting

facility was 'simple, necessary, and sufficient': it invested the physician with relative autonomy, pared away excessive bureaucracy, and avoided unnecessary internments in most cases. With no minimum observation period, cured patients could be released immediately. In contrast with asylums that isolated patients from their familiars, Porot encouraged family visits and held meetings with patients' relatives twice weekly to discuss cases. 'Thanks to these very liberal policies,' the service enjoyed a good reputation in public opinion and achieved strong results: over 50 percent of his patients were discharged as cured after less than a month, and only a fifth remained for more than three.[15]

Despite such persuasive figures, the conservative French Senate rejected these revisions and even the French psychiatric community as a whole found the reforms too threatening to the traditions of institutional power in the asylum.[16] The implementation of Toulouse's program remained confined to a few metropolitan clinics until well after the World War II. Instead, it was in the French North African colonies that these ideas first took hold on a grand scale. The colonies offered a key experimental venue for staging a mental hygienic 'biocracy,' where the sciences of the mind could join forces with the civilizing mission in the interest of public mental health. Antoine Porot brought the major precepts of mental hygiene as developed in his Tunis ward to both European settlers and colonial subjects as he campaigned to open a vast network for psychiatric assistance across North Africa in the 1920s and 1930s.

Unlike the carceral asylums of the Metropole, the institutions that opened in the Maghreb in the 1930s were planned from the outset as psychiatric hospitals, showcases not only for colonial beneficence but also for the advancement of the psychiatric profession. As Porot put it, 'we began with a "tabula rasa" . . . and it was consequently easy – but also necessary – to innovate.'[17] The schematic outline for the Algerian system reflects Porot's conviction that any 'complete program' for mental health care necessitated two lines of defense against mental illness. First, public hospitals in Algiers, Oran, and Constantine would serve as dispensaries, distinguishing acute from chronic patients. The hospital at Blida, which Porot called a 'veritable city for mental and nervous invalids,' constituted a 'second line of assistance . . . for chronic and incurable patients' some 50 kilometers from Algiers, in addition to a range of custodial facilities for retarded children and the senile.[18] The dispensary and social services unit, not the asylum, constituted the system's hub, with the chronic facility relegated to secondary duty. Path-breaking legislation supported this institutional structure: the French–Algerian Governor-General assured physicians' autonomy over mental

assistance by stipulating in 1934 that admissions and releases in the first-line services function exactly like those of any other hospital ward, thereby freeing them from the bureaucratic constraints that tied French asylums to police and the courts.[19]

A sense of celebration marked the implementation of this plan in Algeria, along with similar programs in Morocco and Tunisia. Medical and lay commentators extolled the virtues of these 'model establishment[s] for lunatics' across Algeria's coast, at Berrechid in Morocco, and at Manouba in Tunisia, which one account labeled 'a great and beautiful work' of French civilization.[20] According to the press, the North African insane could now seek care 'in the best conditions of hygiene, tranquility, and security.'[21] Medical results supported such rhetoric. Where cure rates in Metropolitan French asylums reached 10–15 percent at best, the Algerian first-line services were initially far more successful. In 1935, for example, of over 800 patients who entered Algerian services, just over half (441) were released as cured, while only about a third went on to long-term confinement.[22] Porot concluded that not being 'handicapped by antiquated formulae and traditions,' colonial psychiatrists had been able 'to develop projects conforming to the most modern conceptualizations of assistance and scientific data.' Such promising results merited the implementation of such 'modifications' in metropolitan facilities, as Porot wrote in 1936: 'Wherever there is a very large population and a large General Hospital, there should a psychiatric ward, a *totalitarian* service (to use a fashionable expression) not just for sporadic, temporary disturbances ... but *for all Psychiatry*.' Such facilities would include, at the bare minimum, a 'triage ward,' a 'social service,' and a 'teaching ward' to serve the entire hospital's psychiatric needs.[23]

The development of these institutions highlights a second – and more disturbing – pathway for psychiatry's renewal in the colonies. As both the first- and second-line wards filled with patients, they dramatically increased psychiatrists' contact with indigenous North Africans, who constituted roughly half of the patient population in Algeria, and a significant majority of patients in Tunisia and Morocco. Observations of the mentally ill provided the basis for studies that established a scientific foundation for common suspicions about not only Muslim madness, but also about North Africans' normal psychology. Such ideas emphasized connections between culture, biology, and psychology, and members of the Algiers School saw in such research a means of overhauling psychiatry's understanding of the implications of race for mentality.

Psychiatrists had speculated about the relationship between race, climate, and madness since the origins of the profession. Early modern

theories about the effects of climate on bodily equilibrium extended to mental balance as well, and remained influential for much of the nineteenth century. Excessive heat and light were deemed to pose significant dangers for European minds best suited for temperate climes. In British India, then, repatriation was the prevailing form of treatment for unhinged soldiers and settlers.[24] While also subscribing to environmental approaches to mental health, French psychiatrists tended to privilege the place of 'culture' and 'civilization' in their assessments of the epidemiology of insanity. Following the Rousseauist notion that madness marched in step with modern progress – that departure from one's true place in nature meant alienation from one's mental nature as well – psychiatrists such as Pinel and Brierre de Boismont proposed that madness was the price Europeans paid for living in civilization; psychological well-being, by contrast, appeared to be the privilege of so-called primitive populations.[25]

Although such ideas were based more on philosophical precepts than on actual fieldwork, early medical expeditions refined, rather than corrected this logic. The case of Jacques-Joseph Moreau de Tours offers a key example. Having toured North Africa and the eastern Mediterranean, Moreau published a major study of 'Lunatics in the Orient' in France's most prestigious psychiatric journal, the *Annales Médico-Psychologiques*, in 1943.[26] Within his psychiatric paradigm, an absence of enlightened civilization meant that North Africans should suffer from a lower degree of mental alienation than Europeans. But Moreau proposed a major caveat. Redefining madness to mean not merely alienation from one's self, but also from one's social environment, Moreau argued that insanity *was* infrequent in North Africa. Yet he also considered Islamic fatalism to engender a lack of will, and the intense heat and sun of the North African climate to render the population utterly torpid. Few Muslims were 'abnormal' – that is, psychologically distinct from other Muslims – yet Muslim North Africans as a people were essentially abnormal in their normal psychological state.

The relationship between climate, culture, and madness articulated by Moreau and others meant that natives of colonized territories were predisposed to madness – that their naturally degraded nervous systems could easily collapse under certain circumstances. But such a process could affect Europeans just as it affected natives: the stifling heat, combined with a general state of poor health, led quickly to mental breakdown. Many considered that Europeans who migrated to colonial settings took their psychological lives in their hands. Literature teems with references to colonial territories as spaces of insanity, and

specifically to the mental and moral dangers facing European colonialists: Conrad's Kurtz, the mysterious and violent figure who embodies the 'heart of darkness' of human savagery is only one prominent example. A permissive and exotic space, the colonial realm served as a site for the exploration of forbidden human passions; those Europeans whose temperament could not withstand the intense pressures of heavy drinking, drug use, colonial violence, boredom, and intense heat served as symbols of the psychological menace of colonial space.[27]

By 1900 a convergence of factors overwhelmed these hypotheses that considered psychological difference to be a function of climate and culture rather than race.[28] Increasing European settlement in tropical climes was not the least of these: on grounds of political expediency alone, the notion of climatic pathogenicity was certain to fall out of favor in a moment when European nations encouraged dramatic expansion into the colonies. This was especially the case for French Algeria, where dramatic increases in the settler population between 1848 and the turn of the twentieth century facilitated the formation of a distinct cultural identity for Europeans in the colony. For much of the period of military rule in nineteenth-century North Africa, divide-and-conquer policies encouraged fine distinctions among North African populations – divided into Arabs, Berbers, M'zabites, and Jews in addition to national divisions among Algerians, Moroccans, and Tunisians. Such important distinctions persisted, but retained less significance among settlers at the turn of the century, when the firmer division between Europeans and North Africans as a group largely supplanted earlier classifications.[29]

New scientific ideas lent intellectual weight to the notion that biological difference, rather than climate, influenced the relationship between race and psychopathology. Physical anthropologists posited the idea of a measurable biological difference across races.[30] Likewise, the dissemination of Darwinist thought pointed to the role of evolution in the determination of behavior and mentality.[31] By the turn of the twentieth century, thinking about 'mind' in an increasingly biological fashion intersected with a new infatuation with comparative psychology. Social anthropologists, philosophers, and psychiatrists began a nearly obsessive documentation of the functions of what they called 'civilized' or European and 'primitive' mentalities.[32] In France, Lucien Lévy-Bruhl published several volumes on topics like 'primitive mentality,'[33] arguing that while Europeans enjoyed a logical, scientific consciousness, 'the primitive's mentality is essentially mystic.'[34] Psychiatrists and psychologists employed similar distinctions when comparing the mentalities of so-called primitives and of their patients. Freud's

*Totem and Taboo* of 1913 is perhaps the most famous comparison of 'savage' and neurotic mentalities.[35] Others focused more closely on parallels between primitives and paranoid or schizophrenic patients, seeing close affinities between 'paranoid' aspects of primitive mentality – such as belief in sorcery – and the delusional thought characteristic of paranoid schizophrenia.[36]

In the view of colonial psychiatrists, however, such attitudes amounted to a form of armchair diagnosis – and one veered dangerously close to romanticizing 'the primitive mind.' Metropolitan philosophers like Lévy-Bruhl based their studies on others' field notes, and their lack of direct contact with colonial populations led them to overlook the real-life consequences of intellectual debilitation, impulsivity, and fatalism that colonial psychiatrists insisted were the cornerstone of primitive mentality. Porot and his colleagues agreed with many of Lévy-Bruhl's conclusions, but by virtue of their constant interaction with mentally-ill North Africans, they found primitivism a real social problem rather than an intellectual curiosity. Beginning in 1918, Porot and others framed the 'North African mind' as inherently puerile and incapable of coping with the realities of modern civilization.[37] Merging paradigms of hereditary degeneration with common notions about primitive fatalism, French colonial psychiatrists forged a synthesis that connected the behavior of their violent, criminal patients with both Islamic cultural traditions and their suppositions about physical anomalies in North Africans' brain structure.

Colonial psychiatrists thus saw their patients not as sick individuals, but instead as representing dangerous tendencies that were inherent to North Africans' mentality.[38] Like Moreau – and colonial psychiatrists in a number of other domains – they found even ostensibly 'normal' North Africans to exhibit a range of pathological behaviors that rendered the general population inherently dangerous to the social order. As such, they required intense policing and punishment, rather than rehabilitation. Rejecting what they considered the outdated mandate of France's 'mission civilisatrice' in the colonies, Porot and his students insisted that the supposed abnormalities of Muslim culture – including factors like child marriage, which they considered to heighten the North African male's appetite for sexual assault on the innocent – meant that educational initiatives that aimed at the assimilation of the North African population into French culture were doomed to failure.[39] A comparison between the European and North African patients confined at Blida and other facilities demonstrated merely an exacerbation of the normal tendencies seen in the wider, non-hospitalized population,

Porot and his student Jean Sutter pointed out in 1939. The European patient, they argued, 'always' obeyed his 'superior faculties,' whereas the 'primitive' North African patient experienced a 'complete liberation of his . . . instincts,' and obeyed 'the law of all or nothing: in his madness, the native knows no restraint.'[40]

These ideas are familiar from a number of colonial contexts. The British developed similar theories about sub-Saharan Africans and South Asians, for example, and even French intellectual travelers since the early nineteenth century had considered the Muslim world a repository of lurid sexuality, savage violence, and uncontrollable madness. But there is a crucial difference to the Algiers School's studies on North African primitivism and criminality. Besides providing a strong counterbalance to novelists and artists who romanticized 'the Orient' as a permissive space where indulgence in forbidden behaviors reigned, Porot's and others' works also noticeably shaped psychiatric thought in the French metropole. Just as Porot's experimental open service in Tunis encouraged thought about the reform of psychiatric institutions in France, so the Algiers School's research changed ideas about the relationship between race, madness, and crime.

Journals like *Algérie Médicale* and *Tunisie Médicale*, the latter of which Porot himself founded in 1911, provided a venue for communicating ideas about ethnopsychiatry to other colonial practitioners. Such media also enhanced the growing authority of the University of Algiers as a new center for inquiry into ethnicity and insanity. The School's members published in major metropolitan journals as well, and reviews of pieces that originally appeared in colonial publications began to shift thought in France as much as in the colonies. Take, for example, the *Annales Medico-Psychologiques*' review of Porot and Sutter's study of primitivism and its consequences for criminal behavior – originally published in a minor journal. The review highlighted the authors' main points, signaling the 'frequency of . . . instinctive reactions [and] extreme violence' in these patients, but also drew attention to the interest of this research for metropolitan physicians. 'This penetrating analysis of the mentality of the indigenous African [sic], observed in his mother country, should be familiar to those who observe him transplanted into the Metropole, where he becomes one of the most picturesque forms of mental dislocation.'[41] Reviews like these gave a wide audience access to the key principles of the Algiers School's work, and such ideas merited close attention as immigration from North Africa boomed.

Medical attitudes changed demonstrably as these ideas became more widespread. For example, a 1927 study of North African patients in Paris still described them in paternalistic terms: 'These men, in a word, are big children.'[42] But as the Algiers School's ideas achieved a higher degree of medical currency, metropolitan authors began to concede the point made by psychiatrist Don Côme Arrii in his Algiers Medical Faculty thesis in 1926: that North Africans who 'mingle more and more in our national life bring the psychopathological heritage of their race to our civilization.'[43] By 1952, psychiatrists in Marseille cited the Algiers School's works to explain the numbers of North African psychopaths who entered their wards. Arguing that Muslims remained fundamentally incongruous with civilized life in France, they concluded that 'repatriation appears to be the only favorable solution.'[44] Two years later, an extensive study conducted at the Sainte-Anne hospital in Paris blamed the 'Muslim new wave' of immigration for a general decline in France's mental hygiene.[45] Again citing Porot and his students extensively, they recommended tighter immigration controls as a means of ensuring the nation's aggregate mental prophylaxis.

Publications from the Algiers School's members gradually enhanced the group's authority, and meetings of the Congress of French Alienists and Neurologists in Rabat in 1933 and Algiers in 1938 also cast a national spotlight on the institutional and academic achievements of French psychiatrists in North Africa. But the group was not content to limit its significance to ethnopsychiatric research, as a series of later papers reveals. Mounting patient populations also provided the Algiers School with an enormous data set for experimenting with radical new therapies. The efficient, modern institutions of French North Africa helped to avoid unnecessary internments, but they also expanded psychiatry's reach, bringing more patients into contact with the system. As more patients flooded in, second-line facilities for chronic cases were unable to keep up with rising rates of confinement. This phenomenon was global in nature: the 1930s and 1940s witnessed inundation of asylums and hospitals throughout Europe and the United States as institutions 'silted up,' to use Jack Pressman's description of American state asylums in the period.[46] At the end of the line, chronic patients filled beds permanently, and the crisis in confinement brought with it the 'heroic age' of mental medicine, as psychiatrists desperate to find a physical basis for madness experimented with increasingly radical methods for unclogging beds.

In the early 1930s, somatic interventions marked the leading edge of psychiatric practice. Ladislaz Meduna's cardiazol injections promised to counter schizophrenia by inducing seizures, conforming to the belief

that epilepsy and schizophrenia were incompatible. Manfred Sakel's insulin therapy sent the patient into hypoglycemic coma in order to rupture 'functional synergies' between mind and body. But significant complications offset their promise – cardiazol produced uncontrollable convulsions that often broke patients' bones in addition to producing a 'vivid anxiety' between injection and onset, while insulin shock frequently entailed cardiac arrest, pulmonary edema, and irreversible coma as unfortunate complications. Electroshock, developed by Italian psychiatrist Ugo Cerletti after he learned the uses of electric shock to stun pigs in a Roman slaughterhouse, promised to be a 'simpler, non toxic' alternative to these methods, and Cerletti and his partner Lucio Bini began human clinical trials with electro-convulsive therapy (ECT) on a schizophrenic patient immediately after they calculated the threshold between convulsion and death in pigs.[47]

The implementation of such treatments in France and North Africa exposes a general pattern of metropolitan caution and intense experimentation at the periphery. ECT presents the clearest example of this phenomenon. Early French publications approach the topic not only with interest, but also clear trepidation. At Neuilly-sur-Marne, Doctors Lapipe and Rondepierre began the first, rather restrained, human trials of ECT in France in 1941, consisting of 250 sessions on 15 patients.[48] At the same time, *L'Encéphale*, a leading psychiatric journal, urged caution concerning all of the 'so-called shock treatments.' Dr Henri Baruk, the journal's editor and a long-time arbiter of the French psychiatric profession, argued that 'a fearsome cloud of the unknown hovers over these otherwise brutal, blind, and inhumane methods.' Trials on rhesus macaques showed serious consequences for brain circulation, and Baruk implored his colleagues to seek 'rational, safe, and truly humane' alternatives. His conclusion pleaded for the return of an approach that characterized his discipline a century earlier: Baruk implored his colleagues to forsake such radical inventions for 'the very important and too often forgotten moral treatment' for mental illness.[49]

Colonial psychiatrists, by contrast, were quick to boast about the innovative and scientific character of their therapeutic activity. They proudly claimed that every hospital admission entailed a blood test, a lumbar puncture, and consequent lab work; that they deployed cocktails of mercury, arsenic, and cyanide in the struggle against syphilis; that they ameliorated schizophrenia through the administration of thousands of insulin and cardiazol shocks.[50] According to one Algerian doctor, 'daring treatments like these have revolutionized therapy and given these institutions more and more of a "hospital" character.' Such

statements betray as much anxiety about the scientific status of psychiatry at the margins as they do insight into practices: their authors are desperate to cast their activities in a scientific light. But they also reveal themselves as far more experimentally bent than their metropolitan colleagues, especially concerning ECT. While French doctors pursued animal tests – and some small-scale human trials – electroshock immediately became a bedrock of therapy in the Maghreb, reflected in a comparison of experimental uses in the early 1940s. In 1941 – the same year in which Lapipe and Rondepierre were still conducting trials on rabbits – Pierre Maréschal, the director of the Manouba hospital in Tunis, revealed his zealous experimentalism as he told a French psychiatric congress at Montpellier that he and his colleagues administered ECT 'regularly and systematically to all patients capable of supporting it.'[51] Even a pregnant 25 year-old woman who presented a 'frenzied confusional agitation,' received the treatment. A first session produced uterine contractions; however, they administered a second treatment three days later, this time inducing labor and producing 'a viable infant, one month before term.'[52]

Sources suggest an abusive approach to ECT. A psychiatrist in Rabat, for example, told of using ECT on a recalcitrant Moroccan patient to obtain 'a confession about his sexual life and his social . . . conduct,' presaging the horrifying uses of electricity during the Algerian war.[53] At the same time, French doctors in Algeria employed ECT as a diagnostic tool to detect simulators. But aside from these clear abuses the explicitly medical usage of ECT indicates a broader pattern of experimentation in North Africa that persisted for the next two decades. Maurice Porot, Antoine Porot's son and director of the psychiatric clinic in Algiers, tested the limits of the promising therapy, experimenting widely on tubercular patients – despite the frequent complication of lung abscesses – and also with pregnant women and cardiac patients to determine the feasibility of application even where ECT was strongly counterindicated. Concerning his trials with tubercular patients in Algeria during the World War II, he subsequently boasted that even in this era before streptomycin, and with a severely malnourished patient base suffering from wartime deprivation, out of 41 cases, only nine deaths could be connected directly to treatment; this 22 percent mortality rate was promising enough to merit further study.[54]

Maurice Porot's papers on psychosurgery indicate that he took this experimentalist attitude into more invasive domains in the late 1940s and early 1950s. French psychiatrists on both sides of the Mediterranean

were slower to deploy Portuguese psychosurgeon Egas Moniz's Nobel-prize winning techniques than their British or American colleagues. But once the therapy became a common component in the francophone repertoire Algerian practitioners again embraced the cutting edge. Porot published the first major paper on leucotomy for a French audience in 1947, for example, peppering a synthesis of foreign works with his own observations. In the next 7 years, Porot performed psychosurgeries on over 200 patients, a number that matched that of American state hospitals in the same period whose patient populations doubled and tripled those of Algeria.[55] As Henri Baruk again urged restraint, arguing that time would prove leucotomy an ineffective and brutal procedure, Porot insisted that any permanent damage caused through psychosurgery represented a change for the better:

> [W]hen one speaks of the 'transformation of the personality,' we must first remember that it is a diseased personality that we are operating on, and not a healthy personality. In fact, the psycho-surgical intervention . . . allows the patient's former personality to reappear, generally with a deficit that is due much more to the prior illness than to the intervention.

Supporting this view, Porot cited the case of a law student who spent several years at Blida: 'after a lobotomy, he spontaneously resumed his studies, finished them, registered with the bar, and currently litigates successfully.' If psychosurgery killed human subjectivity, the procedure killed the sick subject, allowing the healthy one to re-emerge.

To be sure, some French practitioners in the Metropole were less reluctant than Baruk to deploy psychosurgical techniques, and Maurice Porot was by no means leucotomy's most enthusiastic French advocate. But through frequent publications and debates, Porot positioned himself as a rising star in the somatic treatment of mental illness, just as his father had paved the way for psychiatry's social interventions and the development of ethnopsychiatric knowledge. These ambitions went beyond the personal, in the interest of establishing a new scientific center for the advancement of psychiatry on the margins of the French empire. Henri Aubin, the director of the psychiatric clinic at Oran, set this problem in relief in 1945. Aubin argued that since 1918 psychiatry had become 'a precious instrument of research in the hands of psychologists, an indispensable guide for the judge and the criminologist, [and] the inseparable companion of the pedagogue.' But this work remained in its infancy. Ethnopsychiatry and medical interventions demanded

further study, and Aubin quickly staked new claims for the Algiers School: 'the University of Algiers, a natural link between the Metropole and its global Empire, appears especially qualified' to undertake this mission.[56]

A joint publication of 1952 marks this apotheosis of the Algiers School. Together with seven other members of the School, the Porots and Aubin produced the 'alphabetical manual for clinical, therapeutic, and medico-legal psychiatry' for the Presses Universitaires de France.[57] This practical guide was aimed at the widest possible audience, designed to bring the essence of contemporary psychiatric knowledge to anyone's finger-tips. The text contains frequent entries on ethnopsychiatric matters, including topics like 'the psychopathology of North Africans' and 'primitivism,' in addition to dozens of casual references to North Africans in entries on criminal impulses, jealousy, sexual perversions, and homicides. But the manual's core is its hundreds of entries detailing diagnosis, the psychiatric implications of somatic conditions, and the latest therapeutic procedures, including ECT and psychosurgery.

The text is crucial because it asserts the School's authority on not only ethnopsychiatric issues, but also general psychiatry. More importantly, the French medical establishment responded enthusiastically to the manual's publication, and indicated the acceptance of this new center for psychiatric knowledge. 'This original presentation,' wrote *La Presse médicale*'s critic, 'will be the indispensable instrument of labor for more or less all who are interested in psychiatry.'[58] The *Annales* was even more effusive: the reviewer claimed that 'we cannot laud Professor Porot enough for having conceived the idea of producing a psychiatric lexicon,' and acknowledged that the Professor's 'long, unanimously appreciated career of teaching psychiatry designates him quite particularly for this delicate task.' More than a dictionary, this project was psychiatry itself in 600 entries, according to the critic. Porot's 'long and far-reaching clinical experience' and the contributions of collaborators 'educated by him' meant that this text would 'complete and advance' the work of 'the great treatises of psychiatry.'[59]

The Algiers School's critics have charged that ideology contaminated their work, that ethnopsychiatry constituted a pseudo-science that existed purely for the defense of the colonial administration. Close scrutiny, however, reveals a more complex story in the Algiers School's development. Porot's and his students' works often betray a manifest racism and enthusiastic support for the colonial order. But these works also met the accepted gold standard of European psychiatry in the first half of the twentieth century. More than finding a welcoming audience for

its ideas in the colonies, by the early 1950s the Algiers School achieved hegemony in France as a new center for scientific inquiry, not only in ethnopsychiatric matters but also in general psychiatry. As French practitioners grappled with the issue of reforming an obsolete asylum system in the interwar period, and struggled through the German occupation, the Algiers School charged ahead with a new institutional order and a research program that eventually met with enthusiastic acceptance in France. Practical considerations like the development of new hospitals from a 'blank slate,' as Porot called it, and the ability to practice outside the restrictions of the Law of 1838 enhanced colonial psychiatry's ability to innovate while practitioners in France remained shackled.

The geographic, political, and professional contexts of French North Africa in the first half of the twentieth century are crucial for understanding the Algiers School's development and its concern with innovation. By French medical standards, no psychiatric system existed in North Africa at the moment of French conquest; certainly, no entrenched psychiatric establishment could fend off the development of a two-line system for patient care as it did in France. Likewise, daily contact with Algerian, Tunisian, and Moroccan patients gave colonial psychiatrists an extensive research base for developing ethnopsychiatric ideas. Moreover, the looser regulation of the psychiatric discipline itself in the colonies also paved the way for somatic experimentation in the mid-twentieth century. By political decree, French psychiatrists in the Maghreb operated under their own authority (within limits), as opposed to their metropolitan colleagues forced to work at the behest of the prefectures. They argued that this autonomy facilitated the march of science; but it also limited patients' protections. Maurice Porot's position on patient consent for psychosurgery provides a key example. Candidates were by definition in no position to offer their informed consent. But poorly informed families proved no better: they 'can demand a pointless treatment or refuse an essential treatment.' Moreover, Algerian hospitals that drew their patients from great distances throughout the colony rendered informed consent from distant families – who in most cases spoke only Arabic, or who had abandoned unwanted insane relatives to psychiatric authorities to begin with – nearly impossible. In these situations, Porot argued, 'the treating physician' was best able to consent to the procedure.'[60] Such flexibility reflects the potential downside of Algeria's limited regulation of psychiatric practices, at least as far as the patients were concerned.

For the physicians, this environment proved not only a crucible for scientific inquiry, but also an incitement to scientific practice. We have

to recall the origins of this new center in French colonialism's civilizing mission. Marshal Hubert Lyautey, the French conqueror of Morocco, claimed in 1933 that 'the physician is the primary and most effective of our agents of penetration and pacification.'[61] Colonial medicine and psychiatry held the potential to conquer new domains through the deployment of a scientific arsenal. The papers of the Algiers School reflect this imperative at every turn. Congress meetings in Algiers in 1938 and Rabat in 1933 displayed the new institutions to an international audience as a symbol of the combined achievements of French colonialism and psychiatry, and witnesses extolled 'the civilizing work of benevolent France in its expansion.' Such institutions could 'develop the manifestations of modern life, above all from the hygienic point of view' in a desolate region.[62]

The institutional structures of colonial psychiatry, such a powerful symbol of the civilizing mission, also enjoined colonial psychiatrists in a battle against indigenous pathology. As one psychiatrist asserted, 'It is indispensable . . . that the [Moroccan] population feels in its physical and psychological health the benefits that today's medicine is capable of bringing to the sick in mind.'[63] Colonial psychiatrists occupied the front lines in a struggle between western biomedicine and what they considered superstitious tradition. The most 'daring innovation' of the colonial two-line system of defense against madness – hospitals, not asylums – was its existence as a base of operations for the relentless march of science across the obstacles of contradictory beliefs. For North African Muslims, *j'nun* or possessing spirits caused convulsions, hallucinations, and maniacal outbursts. For the French psychiatrist, epilepsy, delirium, and schizophrenia offered better explanatory labels for these symptoms. For North Africans, mental illnesses were phenomena; for the French, they were manifestations.

This calls attention to those voices so far absent from this account: the patients. Case reports and other accounts indicate that they entered psychiatric hospitals for a wide range of reasons, and that they reacted to what they encountered there in sharply diverging ways. Most were involuntarily confined: either police brought them to psychiatric services after public outbursts, or family members abandoned them to institutional confinement. Others came of their own volition after a variety of traditional interventions had failed, or because treatment in French hospitals was free.[64] Regardless, what they encountered in hospitals bent on experimentation proved a striking contrast with what they had experienced in other settings. Case notes show that patients constantly requested talismans, incantations, and trance therapies from what they

considered European marabouts, or healers. Lumbar punctures, cardiazol injections, electroshock, and psychosurgery proved harsh alternatives, often eliciting strong reactions.

North Africans' responses to ECT are the best documented. Some, like the author Kateb Yacine, whose mother was confined at Blida, found ECT a powerful metaphor for colonialism's efforts at social control, as it appears in his literary works.[65] But others still embraced the treatment. Some of the most curious figures concern Pierre Maréschal's trials of ECT in the early 1940s at Manouba. According to one orderly, treatment at Manouba was 'an assembly-line of electroshock.... [A]ll patients, even epileptics passed through electroshock as if we were dumping sacks in a factory, one after another.' Yet 'families said nothing' about the treatment: 'They had a madman, they were happy some took care of him.'[66] This applied to 94 outpatients as well, on whom Maréschal conducted an extensive trial. Of the 94, 14 discontinued treatment before the end of the course. But most startling is that 80 of them continued with the treatment – especially in the era before paralytic agents and general anesthesia rendered the treatment relatively benign.[67] While some North Africans found psychiatry to be a brutal discipline and an extension of the colonial social order into the domain of the mind, others, like these outpatients, accepted harsh side effects as a necessary cost for receiving what they saw as the benefits of western medicine.

Historical circumstances favored the rise of the Algiers School within the French medical hierarchy, but they also precipitated its decline. The decolonization struggles of the 1950s witnessed the School's struggle for its very existence. The Algerian war temporarily heightened interest in the school's work – Antoine Porot and his colleague Charles Bardenat, for example, provided a captivating analysis of the FLN's methods, ascribing their violent tactics to the character defects of North African Muslims[68] – but France's loss forced the dissolution of the group. But the physical disbanding of the School was only one circumstance that ended the group's influence, because at the same moment psychiatry itself began to move in different directions from those that marked the School's contributions. Colonial psychiatrists had seized the initiative on mental hygiene, ethnopsychiatry, and somatic treatment, but psychiatry's most lasting innovation of the century passed them by. In 1952, Jean Delay and Pierre Deniker of the Sainte-Anne hospital in Paris sent shock waves through the global psychiatric community with a series of publications on their extraordinary successes treating schizophrenic patients with a compound called 4560 RP – or chlorpromazine. Curiously, an antecedent of what became a psychiatric wonder

drug in the 1950s and 1960s had first been tested in Tunisia. Henri Laborit, a military surgeon, experimented there with the antihistamine promethazine to control shock, and noted a 'euphoric quietude' in his patients. But although he suggested the drug's potential uses to a French psychiatrist in Tunisia, the psychiatrist remained uninterested, which proved a substantial missed opportunity. Delay and Deniker became luminaries, re-establishing Parisian prominence by embracing the technology as the French empire itself began to disintegrate, and pharmaceutical companies replaced psychiatric schools as the new core of the discipline.[69]

While fascinating recent studies have exposed how colonialism shapes scientific development, and how science informs colonial expansion, they have largely ignored exploring psychiatry in the same light. Yet figures like Porot and his students developed a backwater into a leading-edge center, and the reception of their ideas in the Metropole reflects a growing interest in their work in the first half of the twentieth century. References to Porot's clinic as a leading example of mental hygiene in action; praise of the School's ethnopsychiatric material by French psychiatrists, criminologists, and even the French army; the warm reception of the group's general psychiatric texts like the alphabetical manual – all of these indicate that colonial psychiatrists not only sought to create a new center for French science, but also came close to achieving their goal by 1954. Perhaps ahistorically, we tend to follow Fanon in regarding colonial psychiatrists as politically motivated pseudo-scientists. Yet even as such practices become embarrassing episodes in the history of the disciplines – for instance, when a racist organization nudged French psychiatry in disturbing new directions – they prove fascinating for inquiry into the relationship between science and its contexts, and the historical circumstances surrounding practices in centers and at the margins.

## Notes

For a more extensive treatment of the material in this essay, see my book, Colonial Madness: Psychiatry in French North Africa (Chicago: 2007). Thanks to Sloan Mahone, Megan Vaughan, and Helen Tilley for their comments on earlier drafts of this essay.

1. See especially George Basalla, 'The Spread of Western Science,' *Science* 156, 3775 (1967) 611–22.
2. On the changing historiography of colonial science, see Paolo Palladino and Michael Worboys, 'Science and Imperialism,' and Lewis Pyenson, 'Cultural Imperialism and Exact Sciences Revisited,' *Isis*, 84 (1993) 91–108. Key examples include Roy MacLeod, 'On Visiting the "Moving Metropolis":

Reflections on the Architecture of Imperial Science,' *Scientific Colonialism: A Cross-Cultural Comparison*, ed. Nathan Reingold and Marc Rothenberg (Washington, DC: 1987), pp. 217–49; Kim Pelis, 'Prophet for Profit in French North Africa: Charles Nicolle and the Pasteur Institute of Tunis, 1903–1936,' *Bulletin of the History of Medicine* 71, 4 (1997) 583–622; Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton: 1999); Michael Adas, *Machines as the Measure of Men: Science, Technology, and Ideologies of Western Dominance* (Ithaca: 1990); Peter Redfield, *Space in the Tropics: From Convicts to Rockets in French Guiana* (Berkeley: 2000); Mark Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1600–1850* (New York: 1997); and several essays in Roy MacLeod, *Nature and Empire: Science and the Colonial Enterprise* (*Osiris*, Second Series, vol. 15; Chicago: 2001).

3. See especially Paul Rabinow, 'Techno-Cosmopolitanism: Governing Morocco,' in *French Modern: Norms and Forms of the Social Environment* (Chicago: 1995), pp. 277–319; and Gwendolyn Wright, *The Politics of Design in French Colonial Urbanism* (Chicago: 1991). For critical responses to these arguments, see Alice Conklin, *A Mission to Civilize: The Republican Idea of Empire in France and West Africa, 1895–1930* (Stanford: 1997); and Daniel J. Sherman, 'The Arts and Sciences of Colonialism,' *French Historical Studies*, 23 (2000) 707–29.
4. J.C. Carothers of Mathari Mental Hospital in Nairobi attracted some significant attention with a range of publications, but his case was anomalous; see Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: 1992); Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (New York: 1995); and Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Rhodesia* (Berkeley: 1999). For India, see Waltraud Ernst, *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (New York: 1991); and James H. Mills, *Madness, Cannabis, and Colonialism: The 'Native Only' Lunatic Asylums of British India, 1857–1900* (London: 2000).
5. Concerning the last example, see Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (New York: 1987), p. 297; she notes that provincial deputies objected that the law governing the confinement of the insane was 'cut to the measure of the capital' and only applied 'with great difficulty to the provinces,' where facilities remained sparse.
6. Frantz Fanon, *The Wretched of the Earth*, trans. by Constance Farrington (New York: 1963).
7. See especially Robert Berthelier, *L'homme maghrébin dans la littérature psychiatrique* (Paris: 1994).
8. For examples of this rhetoric, see anonymous letter to the Ministère des Affaires Etrangères; Archives du Ministère des Affaires Etrangères (MAE), Paris: Maroc 1283, M-63-3; and Lwoff and Sérieux, 'Sur quelques moyens de contrainte appliqués aux aliénés au Maroc,' *Bulletin de la Société clinique de médecine mentale* 4 (1911): 168–74.
9. See proceedings of the *Congrès des médecins aliénistes et neurologistes de France et de pays de langue française*, XXIIe Session: Tunis, 1912 (2 vols; Paris: 1912). Henceforth: *Congrès*, venue, and date.
10. See Goldstein, *Console and Classify*, 322–77.

11. 'Ligue de Prophylaxie et d'Hygiène Mentales: Son But–Son Organisation,' undated flyer (1921); Archives Nationales de France, Series F[22] 529.
12. Toulouse, 'Le problème de la prophylaxie mentale,' 7, 13.
13. Idem, 'Ligue de Prophylaxie et d'Hygiène Mentales.'
14. Toulouse and Dupouy, 'Les services ouverts et la législation des aliénés: Rapport présenté à la Conférence Internationale de Psychiatrie et d'Hygiène mentale' (n. d. [1929]), 5–6. AN F[22] 529.
15. Antoine Porot, 'Résultats d'une expérience de "Service ouvert" pour psychopathes en Tunisie,' *Informateur des aliénistes* 18, 5 (May 1923): 111–4.
16. On the conservative nature of the French psychiatric community, see Jean-Bernard Wojciechowski's two-volume *Hygiène mentale et hygiène sociale* (Paris: 1997), esp. volume II: *La Ligue d'Hygiène et de prophylaxie mentales et l'action du docteur Edouard Toulouse (1865–1947) au cours de l'entre-deux-guerres*. See also Elisabeth Roudinesco, *La Bataille de cent ans: Histoire de la psychanalyse en France* (2 vols; Paris: 1982–85).
17. Porot, 'Résultats d'une expérience,' 112.
18. Idem, 'Les services hospitaliers de psychiatrie dans l'Afrique du Nord (Algérie et Tunisie),' *AMP* 94, I (1936), 794.
19. 'Instruction sur le fonctionnement des Services de Psychiatrie de 1[re] ligne dans les hôpitaux d'Alger, Constantine et Oran,' 10 August 1934.
20. 'Une grande belle oeuvre française,' *La dépêche tunisienne*, 19 February 1931.
21. Marise Périale, *Maroc à 60 Kms à l'heure* (Casablanca: Réunies, 1936), 234, and 'Les formations neuro-psychiatriques du Maroc,' *Paris Médical*, 25 January 1936, 86; 'Le traitement des aliénés en Algérie,' *Echo d'Alger*, 3 July 1933, 3. See also Raoul Vadon, 'L'Assistance médicale des psychopathes en Tunisie' (Med. thesis; Marseilles, 1935), 13, 51.
22. 'Fonctionnement de l'Assistance psychiatrique en Algérie,' Assemblées Financières Algériennes (1936).
23. Porot, 'Les services hospitaliers de psychiatrie.'
24. Ernst, *Mad Tales from the Raj*, esp. 115–20.
25. See Françoise Jacob, 'La psychiatrie française face au monde colonial au xix[e] siècle,' in *Découvertes et explorateurs: Actes du Colloque International, Bordeaux 12–14 Juin 1992. VIIe Colloque d'Histoire au Présent* (Paris: 1994), pp. 365–73.
26. Joseph Moreau (de Tours), 'Recherches sur les aliénés en Orient,' *AMP* 1 (1843), I.
27. Other literary references include Lady Stanhope, Alphonse de Lamartine's 'Circe of the desert,' who communicates with Egyptians through her madness; *Voyage en Orient*, in *Oeuvres complètes* (40 vols; Paris: 1860–63), VI–VIII, 230. More recently, see Alexandra Fuller, *Don't Let's Go to the Dogs Tonight* (New York: 2001), which describes the toll of alcoholism and insanity on a British settler family in Rhodesia. For histories of the phenomenon, see Ernst, 'European Madness and Gender in Nineteenth-Century British India,' *Social History of Medicine*, 9, 3 (1996) 357–82; also Johannes Fabian, *Out of Their Minds: Reason and Madness in the Exploration of Central Africa* (Berkeley: 2000).
28. Although the theory lived on in different manifestations; see Warwick Anderson, 'The Trespass Speaks: White Masculinity and Colonial Breakdown,' *American Historical Review*, 102 (1997) 1343–70.

29. On the formation of French settler identity, see David Prochaska, *Making Algeria French: Colonialism in Bône, 1870–1920* (New York: 1990). On this transition's effects for racial distinctions, see Patricia Lorcin, *Imperial Identities: Stereotyping, Prejudice, and Race in Colonial Algeria* (London: 1995). On the effects of immigration into France for forging a 'North African' identity, see Mary Dewhurst Lewis, 'The Company of Strangers: Immigration and Citizenship in Interwar Lyon and Marseille' (Ph.D. dissertation, New York University, 2000).
30. Steven Jay Gould, *The Mismeasure of Man* (New York: 1996), pp. 105–75.
31. See Raymond F. Betts, *Assimilation and Association in French Colonial Theory, 1890–1914* (New York: 1961); Robert Nye, *Crime, Madness, and Politics in Modern France* (Princeton: 1984). For a wider view, see Daniel Pick, *Faces of Degeneration: A European Disorder, 1848–1915* (New York: 1989); Richard Wetzell, *Inventing the Criminal: A History of German Criminology, 1880–1945* (Chapel Hill: 2000), pp. 46–60; and Allen Thiher, *Revels in Madness: Insanity in Medicine and Literature* (Ann Arbor: 1999), pp. 195–223.
32. See Henrika Kuklick, *The Savage Within: The Social History of British Anthropology, 1885–1945* (New York: 1991); and David L. Hoyt, 'The Reanimation of the Primitive: *Fin-de-Siècle* Ethnographic Discourse in Western Europe,' *History of Science*, 36 (2001) 331–54. Also Marianna Torgovnick, *Gone Primitive: Savage Intellects, Modern Lives* (Chicago: 1990); and the much stronger James Clifford, *The Predicament of Culture: Twentieth-Century Ethnography, Literature, and Art* (Cambridge, Mass.: 1988).
33. *Les Fonctions mentales dans les sociétés inférieures* (Paris: Alcan, 1910); *La mentalité primitive* (Paris: 1922).
34. Lévy-Bruhl, *Primitive Mentality*, 431.
35. Sigmund Freud, *Totem and Taboo: Some Points of Agreement between the Mental Lives of Savages and Neurotics*, in James Strachey, ed. and trans., *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (24 vols; London: 1953–74), XIII, 102–61.
36. Louis Lauriol, *Quelques remarques sur les maladies mentales aux colonies* (Paris: Faculté de Médicine, 1938), pp. 55–6; Georges Dumas, 'Mentalité paranoïde et mentalité primitive,' *AMP,* 92 (1934), I: 754–62; and Pinkus-Jacques Bursztyn, *Schizophrénie et mentalité primitive* (Paris: Faculté de Médicine, 1935), 74.
37. Antoine Porot, 'Notes de psychiatrie musulmane,' *AMP*, 76 (May 1918), 377–84.
38. As Sadowsky points out for the case of British Nigeria; see *Imperial Bedlam*, 98.
39. For this observation about sexual pathology and Islamic social mores, see Don Côme Arrii, 'De l'impulsivité criminelle chez l'indigène algérien' (Med. thesis; Algiers, 1926), 41–2.
40. Antoine Porot and Jean Sutter, 'Le "primitivisme" des indigènes Nord-Africains. Ses incidences en pathologie mentale,' *Sud médical et chirurgical* (15 April 1939), 226–41.
41. Paul Courbon, review of Porot and Sutter, 'Le primitivisme des indigènes nord-africains,' *AMP*, 97 (1939), II: 440.
42. A. Fribourg-Blanc, 'L'état mental des indigènes de l'Afrique du Nord et leurs réactions psychopathiques,' *Hygiène Mentale*, 22 (1927), 135–44.

43. Arrii, 'De l'impulsivité criminelle,' 13.
44. J. Alliez and H. Descombes, 'Réflexions sur le comportement psychopathologique d'une série de nord-africains musulmans immigrés,' *AMP*, 110 (1952), II: 150–6.
45. G. Daumezon, Y. Champion, and J. Champion-Basset, *L'assistance psychiatrique aux malades mentaux d'origine nord-africaine musulmane en Métropole: Monographie de l'Institut National d'Hygiène no. 14* (Paris: 1957).
46. Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (New York: 1997).
47. Cerletti and Bini, 'L'Elettroshock,' *Archivio generale di neurologia, psichiatria e psicoanalisi*, 19 (1938) 266–68.
48. André Plichet, 'L'électro-choc: Le traitement des affections mentales par les crises convulsives électriques,' *La Presse médicale* (20–23 November 1940), 937–39 (hereafter *PM*). M. Lapipe and J. Rondepierre, 'Essai d'un appareil français pour l'électrochoc,' *PM* (28–31 May 1941), 582, and 'L'électro-choc (2e note): Premières impressions cliniques d'après 250 crises; étude des conditions nécessaires à leur déclenchement,' *PM* (1–4 October 1941), 1069.
49. H. Baruk, David, Racine, Vallancien, and Mlle Owsianik, 'Etude expérimentale chez le lapin et le singe des modifications de la circulation cérébrale dans le coma insulinique, l'épilepsie cardiazolique, l'électrochoc et au cours de l'action de la folliculine et du scopochlorase,' *Encéphale*, 35 (1942–45), 81–89.
50. Porot, 'L'oeuvre psychiatrique,' 364.
51. Maréschal, Ben Soltane, and Corcos, 'Résultats du traitement par l'électrochoc,' 341–43. In a brief aperçu historique on electroshock, Dr René Ebtinger, *Aspects psychopathologiques du post-electrochoc* (Colmar: Imprimerie Alsatia Colmar, 1958), 25, referred to this meeting of the Congrès as an étape marquante in the history of electroshock.
52. Maréschal *et al.*, 'Résultats,' 345.
53. G. Houssin, 'Un cas de confusion avec onirisme et auto-analyse à la suite d'un électro-choc. Evolution vers la guérison en 24 heures,' *Maroc-Médical* (April 1949), 228. My italics.
54. Maurice Porot and A. Cohen-Tenoudji, 'Tuberculose et traitements psychiatriques de choc,' AMP, 113 (1955), I: 376–408. Also Maurice Porot, 'Electrochocs et cardiopathies,' *AMP*, 113 (1955), II: 814–21.
55. Maurice Porot and Pierre Descuns, 'Etat actuel de la psycho-chirurgie,' *Afrique française chirurgicale*, 13, 6 (1955), 525–37; 532. Joel Braslow has determined, for example, that physicians performed 245 lobotomies at Stockton State Hospital in California in the same period (1947–54), but this hospital held nearly 5000 patients. Blida, by contrast, housed only 2200 patients in 1955.
56. Henri Aubin, 'Esquisse d'une ethno-psycho-pathologie,' *L'Algérie Médicale*, 5–6 (1945), 174–9.
57. Antoine Porot, ed., *Manuel alphabétique de psychiatrie clinique, thérapeutique, et médico-légale* (Paris: 1952–96).
58. André Plichet, review of *Manuel* 1, *La Presse médicale*, 60, 40 (11 June 1952), 879.
59. René Charpentier, review of *Manuel* 1, *AMP*, 110 (1952), I: 649–50.
60. Porot and Descuns, 'Etat actuel,' 537.

61. Letter from Lyautey to Guillain, 17 March 1933, printed in *Congrès* (Rabat: 1933), 73.
62. Congrès at Rabat (1933).
63. Ibid.
64. See, for example, the case of Zohra Ya., in Suzanne Taieb, 'Les idées d'influence dans la pathologie mentale de l'Indigène Nord-Africain. Le Rôle des superstitions' (Med. thesis; Algiers: Heintz, 1939).
65. See especially 'Le cadavre encerclé,' in the collection *Le cercle de représailles* (Paris: Seuil, 1959); but also *Nedjma* (Paris: Seuil, 1956), and 'La femme sauvage,' in *L'oeuvre en fragments: Inédits littéraires et textes retrouvés*, ed. by Jacqueline Arnaud (Paris: 1986).
66. Cited in Abdelhamid Bouzgarrou, 'A propos d'une expérience de Transformation Institutionnelle au niveau d'un service de psychiatrie' (Med. thesis; Tunis, 1978–79), Institut de Belles Lettres Arabes, Tunis; emphasis in original.
67. Maréschal, Ben Soltane, and Corcos, 'Résultats du traitement par l'électrochoc,' 341–3.
68. Antoine Porot and Charles Bardenat, *Psychiatrie médico-légale* (Paris: 1959), p. 305.
69. See Judith Swazey, *Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation* (Cambridge, Mass.: 1973), p. 79.

# 3

# East African Psychiatry and the Practical Problems of Empire

*Sloan Mahone*

H.L. Gordon first exercised his philosophical contemplation of the causes of African 'backwardness' from his farm in Kenya early in the 1920s. Gordon spent his days as a self-described medical farmer until his posting to Mathari Mental Hospital in Nairobi afforded him the opportunity to provide the Kenya government with the evidence to support his developing theories.[1] In 1932, the *British Medical Journal* published a summary of Gordon's work with pathologist, F.W. Vint that averred: 'Dr. Gordon has found that a low degree of mentality is widely prevalent, constituting what in a European community would be a social danger.'[2] The author, a colleague of Gordon's, concluded that should such differences between the European and African mind be shown, efforts to educate the African to the standard of the European could prove to be either futile or disastrous. Kenya Colony provided an ideal environment for the application of medical science, particularly the psychological sciences, to the challenges of governance just as Gordon had hoped. With his help, the types of mental disorders found at Mathari were scrutinized for possible associations with the educability or, more specifically, the natural limits to the education of the African subject.

Psychiatry, or any form of psychological medicine, as a discipline was poorly represented in the colonial context in East Africa, but despite the lack of institutional support and resources and an inconsistent medical agenda on the part of colonial governments, an ad hoc professionalism grew out of the small network of East African asylums in Kenya, Uganda, Tanganyika and Zanzibar.[3] As a result, an 'East African school'[4] of psychiatry emerged and managed a degree of intellectual autonomy and authority within the colonies as representative of baseline psychological research conducted from the field. The history of psychiatry in

East Africa (most notably Kenya) has received a fair amount of attention, perhaps prompted by the prolific and somewhat flamboyant nature of some of its colonial participants. Jock McCulloch has written the history of 'ethnopsychiatry', spanning from roughly 1900 to 1960, and characterized by 'its own subjects, its own plant, and its own areas of expertise'.[5] The practice of psychiatry existed in East Africa certainly. Some physicians were referred to as 'psychiatrists' and, as they operated mental hospitals, they were given authority over those issues where psychological evaluation might play a significant role, such as interviewing the accused in criminal proceedings or providing commentary on social processes or movements that appeared to be 'psychological' in nature. From the outset, however, it is important to note that these physicians were rarely trained in psychiatry or any form of psychological medicine until the mid-1940s.[6] Perhaps more significantly, psychiatric ideas often found their expression outside of the medical domain as administrators and high-level government officials assessed African behaviour in psychological terms that sometimes countered general medical opinion. The often insular nature of colonial knowledge – with references made to annual reports, district and provincial records, 'handing-over' books and published ethnographies written by colonial administrators – all helped to create a body of common knowledge and accepted 'evidence' that could be called upon to inform future policy in the region.

As Megan Vaughan has noted generally for colonial approaches to medicine and psychology, the process of 'othering' that often characterizes approaches to those deemed 'mad', had already occurred in a colonial environment that did not question the innate superiority of white over black and therefore did not need the 'madness' label to subordinate the colonial subject.[7] For East Africa it is helpful to differentiate those processes that may be defined as 'tools of social control' such as the extensive prison and detention system, labour laws, the tax system and deportation strategies with the very different process of intellectual rationale for colonial rule for which psychiatric ideas would become much more useful.

One innovation from Kenya that helped to ensure not only the dominance of its own medical reputation, but also succeeded in engendering a greater sense of unity among physicians in East African territories as a single region, was the establishment in 1923 of the *Kenya Medical Journal* as a simple cyclostyled pamphlet. This fledgling journal ultimately went a long way to distributing research and clinical notes from East Africa to a much greater audience throughout the colonies and in Britain.

As interest and contributions grew, the journal evolved into the *Kenya and East African Medical Journal* and eventually, the *East African Medical Journal* (EAMJ) which continues to publish today.[8] By the 1930s the presence of psychiatry in East Africa began to garner some professional respect as the former asylums gradually involved themselves in matters that were more medical than directly related to the prison services from which they emerged. This had little bearing on actual treatment or even the accuracy of psychiatric diagnoses for those confined – admissions were still involuntary, and diagnostic categories remained haphazard and confused. Still, an ad hoc professionalism that expected medical opinion to be taken as authoritative grew out of these emerging hospitals and their patient populations were often highlighted amidst the pages of the EAMJ and increasingly, within mainstream medical journals in Britain. Across medical and social science disciplines, frequent debates about the process of maintaining the Empire and the development of the colonial territories required a wealth of expertise identified and supported by the Colonial Office.[9] One of the most compelling 'practical' questions in inter-war East Africa was the quasi-medical problem of the 'educability' of the African subject, and in terms of policy, the future of 'native education'.

H.L. Gordon was one of the earliest physicians to see the 'practical applications' of his work even if many of his contemporaries did not. One aspect of his research placed dementia praecox into a racial framework stressing that it was the natural 'inferior durability' of brain cells that lead to dementia praecox in Africans.[10] He stressed that this was an even greater danger for those Africans who had been under the influence of European-style education and whose constitutions had been weakened by chronic disease. Gordon's remarks on dementia praecox in Mathari prompted the Director of Medical Services to report:

> The significance of this observation may be very great, and especially as in every case there was a possible association with scholastic education, for as the times move scholastic education will increasingly become a factor of African environment. The questions arise who are to be educated and how?[11]

Technical training was considered in some quarters to be the most appropriate way forward in African education and assessments looked for evidence of the 'special abilities of specific tribes'.[12] The educability debate was most heated in Kenya and stood in contrast to developments in Uganda where medical education for the whole of East Africa

was promoted and institutionalized by the growth of Makerere Medical School.[13] In reality, despite its somewhat progressive stance in relation to Kenya, graduates from Makerere could not obtain full medical degrees until 1963. Prior to this, one's qualification in Uganda produced trained medical aids described as 'capable under some supervision, of running small district stations and hospitals by themselves.'[14] Despite the growth of Makerere's medical program, African trainees were thought to have about a third of the capacity of European doctors but even this attitude represented a significant improvement over the situation in Kenya.[15] Physicians like H.C. Trowell, a proponent of African medical training in Uganda, saw the political agenda behind Gordon's scientific writing, recounting in his unpublished memoirs:

> A . . . sinister attack on any plans to educate Africans was emerging in Kenya in the 1930s . . . Undoubtedly a certain group in Kenya wanted to believe that the future of the country lay in White settlement in the Highlands: Africans would remain hewers of wood and carriers of water to the end of time: another South Africa.[16]

The many associations made by H.L. Gordon between tropical diseases, mental disorders, mental defectiveness and primitivism were generally interwoven with warnings about the potential mental risks to the primitive psyche should education and civilization progress too rapidly. While many of Gordon's strongest pleas for research into African mental capacity were rejected as politically motivated backward thinking, a Carnegie funded study was generating attention in Kenya under the direction of R.A.C. Oliver, a psychologist specializing in intelligence testing.[17] The interest shown in Oliver's work prompted John Gilks from Kenya's Medical Department to make a (unsuccessful) proposal to the Carnegie Corporation to fund an additional study utilizing the neurological expertise of H.L. Gordon, as well as the services of a pathologist (presumably F.W. Vint whose articles accompanied the proposal), an anthropologist, an experimental psychologist, and other key support staff.[18] In a similar proposal to the Colonial Office, Gilks suggested the provision of a psychiatrist to ascertain the relationship between mental disorders in Africans and educability; to classify mental deficiency; and to establish the rate of brain growth and its relationship to African educability.[19] These proposals, additional letters of support from the British Eugenics Society, a resolution of support from the Combined Meeting of the East African Branches of the British Medical Association,[20] and the publicity generated by H.L. Gordon's frequent lectures[21]

ultimately reached the Secretary of State for the Colonies, but in general, the enthusiasm generated among some quarters within East Africa did not result in significant funding from London.[22] The realization that such studies could prove to be politically embarrassing was a concern for some. For others, such attacks on African capacity were met with cynicism, finally prompting the exasperated Director of Education, H.S. Scott to complain 'according to Dr. Gordon, I am engaged in preparing Africans for dementia praecox.'[23]

## The rise of scientific disciplines in East Africa

The usefulness of psychiatry, psychology, social anthropology and related disciplines in providing potential checks on the provision of higher education for Africans, even amidst progressive criticisms, gave some scientific credibility to a long-standing fear that found its most virulent expression in Kenya but was tied specifically to problems of labour throughout the African colonies. Such anxieties can be seen on the agenda of a District Commissioners' meeting held in 1926 which hoped to address 'The Danger of the Uncontrolled Spread of Literary Education Amongst the Akikuyu and its Relation to the Future Labour Problem.' The brewing crisis was thought to be prompting the African's distaste for cultivation and a desire for clerical vocations. The danger lay in the creation of a 'detribolised [sic] discontented and for the most part unemployable section whose education and training have neither been directed towards their own welfare nor to [the] social and economic needs of the country.'[24] Further items on the agenda included a request for the appointment of an investigator to conduct ethnological research and an urgent plea for more accommodation for Africans in Mathari Mental Hospital.

Within the growing historiography of 'colonial psychiatry', Kenya has received ample attention, prompted in part by the influence and notoriety of the most famous 'ethnopsychiatrist', J.C. Carothers, who followed in Gordon's footsteps to run Mathari throughout the 1940s and produced an even greater body of controversial literature on the 'African mind'. Similarly, H.L. Gordon, by virtue of his verbosity, extreme views, and position as symbolic of white settler thinking in Kenya in the 1930s, comes often to the forefront as representative of scientific racism in the African colonies. Gordon's collaborative brain research with F.W. Vint has come to represent the kind of thinking that seemed to differentiate the settler from the civil servant with ideas about racial difference placed unapologetically at the centre of policy debates. Alan Raper's

historical account (1953) of the history of the EAMJ makes special note of the impact of the contributions by Gordon and Vint.

> Soon after the arrival of Dr. Vint in Nairobi, the first papers on morbid anatomy began to appear . . . Vint's *magnum opus* was without a doubt his paper on the cerebral cortex of the African native; though cautiously propounded by the author himself, and more imaginatively by his collaborator Gordon, his results offered such suggestive material to the anthropologist, sociologist, educationalist, and even to the politician, that they attracted widespread attention, and for a time filled the *Journal* with comment and criticism, often acrimonious.[25]

The consecutive tenures of Gordon and Carothers at Mathari produced enough clinical and polemical material to solidify their similar legacies forged primarily by quite specific moments in their respective research careers; Gordon's attempts to resurrect race-centred research using brain size and weight data, a notion that was roundly criticized as archaic in the 1930s; and Carothers' truly infamous statement that the brain of the African 'normal' showed marked similarity to the brain of the leucotomized European.[26] Nevertheless, for the purposes of this analysis, neither snapshot really suffices. Gordon's racially motivated eugenics agenda remained with him until his death in the late 1940s, but his association with Vint's autopsy work was fairly short-lived, was criticized outside of his own intimate professional circles, and represents a fraction of a much more varied bibliography – albeit most of it 'eugenicist' in tone. One aspect of Gordon's writing that has received little attention is his agitation, ironically, for patients' rights – again, with the retention of his usual and deliberate racial interpretation. Racially motivated rationales for colonial policies were certainly the norm inside Kenya and other settler societies, however, the influence of an organized eugenics movement for Kenya seems negligible.[27]

Publicity about the importance of studying the African's unique psychology was easy to generate, however, and Gordon and Vint's collaborative research was well-cited and made the papers in Kenya and in Britain as representative of new research and raw data emanating from the East African territories. Their research questions undoubtedly appealed to lay audiences whose basic assumptions at this time did not prompt them to question the notion that differences between races did indeed exist in some form or another and thus could be measured. At the same time, however, more mainstream scientific criticisms of this re-emergence of

research purporting to show racial differences related to cranial capacity, brain size or brain weight, were also emerging.[28] Anthropometry and craniology had enjoyed decades of scientific credibility and enthusiasm in Britain in the late nineteenth century and had been institutionalized within influential anatomy departments such as the University of Edinburgh where H.L. Gordon had trained.[29] However, by the turn of the century strong criticism was emerging even among those who taught the curricula such as A.C. Haddon, the leader of the famous Torres Straits Expedition, who despite his dislike for craniology, agreed to continue to teach it until something better emerged to take its place.[30]

F.W. Vint's reputation as a pathologist and his articles published without Gordon, had greater longevity and were often cited as baseline data on the brain based upon a large numbers of meticulous autopsies.[31] These studies, and those that later utilized the data, made little or no mention of racial capacity but were used by other researchers as epidemiological evidence of the presence or absence of other organic diseases. Much of Gordon's self-generated publicity was tied to proposals for larger research endeavours that he hoped would be carried out for Kenya and East Africa. When the publicity quieted, Gordon came to be viewed increasingly as troublesome and polemical, and suspected of having a largely political, not scientific, agenda. The suspicion that Gordon was behind certain initiatives drew exasperated responses from officials who otherwise might have supported similar endeavours. In one letter from J.E.W. Flood to Sir T. Stanton in 1937 on a proposal to the Colonial Office for the study of the 'medical aspects of crime' prompted the comment by Flood that 'I am fairly sure that the "medical aspect" is part of Dr. Gordon's campaign so that Kenya may be ready to drop it.'[32] By 1937, Gordon's racial thinking, archaic and dogmatic views; his eugenicist agenda, which allied him primarily to settler interests; his frequent critiques of his medical colleagues; and his relentless rabble-rousing on behalf of the mental hospital in direct insubordination to his superiors, signalled the end to his appointment as psychiatric consult to Mathari.[33]

The dominance of a forceful personality like that of H.L. Gordon has perhaps obscured more nuanced explorations of the 'colonial mind' in East Africa. Physicians and colonial administrators were preoccupied not only with the day-to-day operations of the mental hospital and the medical services, but were also concerned very deeply with assessing the perceived changes to the psychology of the African population as a whole. Jock McCulloch notes that 'the majority of patients at Mathari came from urban areas, and Gordon believed that native

Africans often broke down when they came in contact with civilization. Gordon further developed this idea of a "clash of cultures" in a paper presented in Nairobi in December 1935.'[34] However, the fact that the 'clash of cultures' debate was in no way H.L. Gordon's innovation is important. The great wealth of literature from anthropology, psychology and other disciplines was already deeply involved with developing both theoretical and practical responses to 'culture-contact', 'the clash of cultures', 'acculturation' and the more administratively defined problem of 'detribalization'.

## Psychiatry, anthropology and the 'clash of cultures'

An editorial comment in the EAMJ in 1937 remarked that 'Dr. H.L. Gordon's researches into African anthropology are well known to readers', suggesting that any foray into 'African-ness', perhaps particularly those researches into the mind and character of the African 'native', could be considered synonymous with the science of anthropology.[35] The fact that many colonial physicians and non-medical administrators did, indeed, practice varying degrees of anthropological and ethnographic writing is illustrative of both their esteem for the discipline and their sense that by virtue of their placements in the field they were themselves developing and asserting their own expertise in the production of anthropological data.[36]

Paul Rich points out that the scenario in which British anthropology was led by theoreticians located in the Metropole and guiding a body of researchers in the colonial periphery was overturned by the tremendous impact of Bronislaw Malinowski's groundbreaking research in the Pacific 'which effectively unified both theory and practice within the notion of fieldwork.'[37] The idea that expertise could, and ideally ought to be, generated from immersion in fieldwork was an idea that fit easily into the political and scientific aspirations of physician researchers like H.L. Gordon, J.C. Carothers, and scores of their less well-known brethren. The greatest theoretical and practical problems of Empire fell within the scope of anthropology by virtue of the fact that the subject was a 'primitive' or 'simple race', and within the scope of psychiatry because such 'difference' was assumed to embody a psychology all its own. The age-old associations made between 'blackness' and pathology, writes Sander Gilman, found their most common expressions in the association between blackness and *psycho*pathology.[38] Two intellectual 'problems' that fell jointly under the purview of anthropology and psychiatry were the impact of 'culture-contact' with the resulting phenomenon

of 'acculturation', and the related centuries old question regarding the relationship between 'civilization' and mental disease.

On these two issues, Britain had in East Africa a medico-psychological laboratory and a vast continuous 'virgin field' for its anthropological field-site. These scientific questions united anthropology and psychiatry, at least on some levels, showing promise in providing real data to questions that had been prominent at least since Immanuel Kant published his *Anthropologie* (1798), a treatise on the classification of mental disturbances, and his theory that 'primitive man' rarely experienced mental disorder because he was 'free in his movements'.[39] Kantian theory further proposed that mental disturbance could occur when the primitive became 'maladapted' to his environment.[40]

The view that the practical application of anthropological research should be paramount was widespread but was not without controversy. Jack Goody's historical account of British social anthropology in Africa downplays the 'colonialist' nature of the largely academic anthropological agenda, pointing out that many of the early patrons of research were American foundations with a strong interest in culture change and race but little interest in maintaining the British Empire.[41] Within British academic circles, however, the sentiment toward practical research was ultimately institutionalized in the form of the International Institute of African Languages and Cultures (IIALC) established in 1928. In the Introductory address, Frederick Lugard stressed a key characteristic of the Institute as 'its aims will not be restricted exclusively to the field of scientific study, but will be directed also towards bringing about a closer association of scientific knowledge and research with practical affairs.'[42] This innovation followed years after the Colonial Office had decided that such an application would be beneficial. As early as 1913, officials in Kenya were touting courses in anthropology to be taken in tandem with the Tropical African Services course at the Imperial Institute, adding that officers displaying an aptitude for anthropology should be allowed to pursue further studies during leave times.[43] The discussion of anthropological training continued into the 1940s with an emphasis on the practical needs of colonial officials, suggesting that they would benefit from approaches separate from the normal academic course and should, instead, focus on such issues as 'primitive law', the 'race question', and the transition away from traditional social organization as a result of culture-contact.[44]

The move toward a practical anthropology helped to counter the criticisms that the discipline was too academic, but anthropologists often countered these accusations with criticisms of their own. Lucy Mair

remarked that such critiques of anthropology were prompted by the government's perception that anthropologists had failed to 'provide recipes for the rapid and easy development of the African.'[45] The idea that the Colonial Office desired a quick and easy fix for the problem of ruling Africa turned into an anthropological critique of the Colonial Office itself. Malinowski remarked upon the unnatural political state that came with some key approaches to Empire. 'Direct rule assumes that you can create at one go an entirely new order, that you can transform Africans into semi-civilized pseudo-European citizens within a few years. Indirect rule, on the other hand, recognizes that no such magical rapid transformation can take place....'[46] Melville Herskovits claimed that many of his profession were wary of the growing importance of the idea of an applied anthropology and admitted that the field did 'not as yet know enough about cultures to determine the destinies of peoples who have lost control of the direction of their own affairs because of the superior power of European nations.' He concluded, however, that such a study could not be held as 'less valid because of its possible misuse'.[47]

While Malinowski asserted that anthropology ought to act on the needs of the government, he was also concerned with the pressure on the discipline to keep up with the changes inherent in anthropology's traditional subject matter. Deeply concerned about the 'vanishing raw native' Malinowski warned, 'just as we have reached a certain academic status and developed our methods and theories, our subject-matter threatens to disappear.'[48] Audrey Richards echoed this sentiment regarding the African social situation as a 'revolution', claiming that 'the whole picture of African society has altered more rapidly than the anthropologist's technique.'[49] In an edited monograph on the methodology of studying culture-contact, Malinowski stressed that:

> Anthropology, which used to be the study of beings and things retarded, gradual and backward, is now faced with the difficult task of recording how the 'savage' becomes an active participant in modern civilization, how the African and the Asiatic are being rapidly drawn into partnership with the European in world-wide co-operation and conflict.[50]

Despite the fear that the true specimen of the raw native was rapidly becoming extinct, Malinowski was critical of 'an old anthropology' that would wish to study, and presume to know, the African only as he once was. The American approach, he said, was indicative of the problem 'in their study of the fully detribalised and yankified Indian, our United

States colleagues persistently ignore the Indian as he is and study the Indian-as-he-must-have-been some century or two back.'[51] The way forward should be, he asserted, to study the current state of the changing African 'and then to eliminate those new influences and reconstruct the pre-European status.'[52] By the 1930s, the most pragmatic purpose the IIALC could hope to serve came in the form of its 5-Year Plan, which provided some structure and impetus to the study of problems like detribalization or a phenomenon like acculturation. Acculturation as a process was defined as 'those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups.'[53] Empire's reach was so great, and so unprecedented, said Malinowski, that a 'practical anthropology', should be at the forefront of studying the impact of 'the westernisation of the world'.[54] The only recourse, for the good of both the broader academic and official communities as well as the discipline itself, was to 'take up the "new branch of anthropology" . . . the anthropology of the changing native'.[55] Significantly, such an approach would serve the Colonial administration by assessing the problems of culture-contact by 'marking probable danger-points'.[56]

## The psychology of the detribalized native

From the nineteenth century anthropology was dominated by evolutionary theories that placed peoples and cultures on an imagined linear scale of progress that emphasized stages of development on the path to modernity and civilization. The trouble in relation to the state of African peoples was that they could no longer be seen as sitting easily within their appropriate stage of development and there existed no scientific data to predict what the outcome of such an upheaval might be. Thus, the process of 'acculturation' became the dominant theoretical problem driving much of colonial thinking about the impact of rule and was taken on by anthropologists, 'colonial psychiatrists' and district administrators for decades. Anthropological thinking in the twentieth century stressed the impact of culture-contact in the disintegration of African traditional systems, which were considered once stable but now faced collapse. Within official discourse the process that described African culture as 'breaking down' was referred to as 'detribalization'.[57]

Anthropology's suggestion that African *systems* were in danger of collapse sits in contrast to the distinctly medico-psychological approach

that tied culture-contact to the disintegration of not only African societies, but of the African personality and psyche. The latter observation proposed that the African way of life, traditionally based on the subjugation of the identity of the individual for that of the collective, was rapidly breaking down in the face of an imposed system of governance that treated the African as an individual with regard to property ownership, the payment of taxes, criminal offences and recompense, and even as an 'individual soul to be saved independently of the family or community of which he forms an integral part.'[58] Thus, the stress felt by the African under these circumstances was due to the expectation that he 'show an independence of judgement and action, and to assume a personal responsibility, for which he has had no training either by heredity or environment.'[59] Far from a critique of the imposition of colonial rule, the implication was that with the reality of British occupation, the African subject remained ill prepared for the mode of thinking that would allow for his ultimate (or rapid) success either economically or politically.

The preoccupation with the detribalization of the African subject permeated much of the medical literature on the African mind and mentality in East Africa. Conversely, quasi-medical interpretations of the phenomenon permeated administrative and political documents describing the state of African affairs. District Commissioner, H.E. Lambert's report on 'Disintegration and Reintegration in the Meru Tribe' warned against the extreme of finding 'racial backwardness of the ruled rather than lack of intelligence or imagination in the ruling', citing such examples as 'the invention of special terms – such as Levy-Bruhl's "group-mentality"[60] and Dr. Gordon's "bradyphysis"[61] – as explanations of a phenomenon so little understood.'[62] Although sensitive to some of the biases inherent in much of the medical literature, Lambert offered his own assessment of the pressing problem of the detribalized African. Using a series of agricultural metaphors to illustrate his case, Lambert likened another colonial preoccupation, widespread soil erosion, to the 'general disintegration of the tribal soul' which he felt left 'the African mind exposed to the disorganising action of individualism . . . That it is we who have introduced individualism to the African as a substitute for his own principle of mutuality can scarcely be doubted when we consider how our system has amended his.'[63]

Eventually, assumptions about the too rapid expansion of 'civilization' with its urbanization, increased culture-contact and the influence of mission schools and evangelization would usher in debates about the

ultimate educability of the African, but perhaps more significantly, widespread pessimism about the African capacity for self-government and the true motivations behind a rising African nationalism. Frequently, these debates played out in medico-psychological terms and in wide variety of settings. So tied was the African to his environment and traditions, it was thought, that upsetting this balance might incite such a shock to the collective African nervous system such that whole populations could suffer mental breakdown. The greatest risk was, of course, to those Africans who were caught in between two worlds, bridging the gap precariously between the 'raw native' and fully civilized subject. Semi-educated, working as clerks, aspiring to leadership – in the colonial mindset, these were the natives who represented a population on the verge of catastrophe. All evidence suggested that they were both undermined by their biological constitutions and pushed to the breaking point by the demands of modern civilization.

## Civilization and mental disease

The appearance of a scientifically generated and supported theory of acculturation and the related political problem of detribalization spoke to beliefs about the existence of a personality type that sociologists named the 'marginal man' to depict the human embodiment of a clash of cultures.[64] Similar studies developed the idea of 'peripheral' peoples to connote their development in relative isolation and stressing that previous problems of contact had proceeded on 'more biological lines and on lines concerned with material exchange and exploitation, whereas to-day they are bound up more with economic and intellectual agencies.'[65] The wide acceptance of acculturation as a force in Africa allowed for more specific interpretations of the theory within disciplines like psychiatry, which turned its expertise to questions of the 'new' predisposition to mental disorder likely to be found in colonial territories. Questions remained, however, as to the likely manifestations of mental disorders that were known primarily in a Western context. C.G. Seligman's important article that suggested the absence of Western style mental disorders among Papua-Melanesians would ultimately become known as the 'Seligman error',[66] but in the mid-twentieth century it was considered to be at the cutting edge of psychological research.[67] Much of the psychiatric literature generated from East Africa speculated upon the presence or absence of specific forms of European style mental disorders among Africans. J.C. Carothers asserted that he had never seen a case of melancholia in African men chiefly because they lacked the

Western characteristic of a sense of personal responsibility. However, depressive states could be seen in African women, he said, primarily due to the general misery among older women who were unwanted in their communities after their children had died or their husbands had remarried.[68]

As the application of science to the problems of Empire was given greater emphasis, changing populations were assessed with the aim to providing government with criteria for practical guidance. Eventually the frequent emphasis on psychology took a turn toward a preoccupation with psychopathology and 'danger points'. Increasingly, the process of informing governance was concerned to help the colonial administrator understand not only the general process of acculturation, but in identifying 'indices of maladjustment'.[69] The unprecedented extent to which Africa was perceived to be undergoing change was seen as resulting in the continent as a whole entering into a pathological condition.[70] A published review of C.W. Hobley's ethnography of the Kamba began with the observation that 'nothing augurs better for the future of anthropology than the fact that it has engaged the interest of many of those who administer the primitive peoples in the more remote corners of our Empire ... '[71] However, of particular interest in Hobley's work was his discussion of the psychology of the Kamba, more specifically their predisposition to 'periodic epidemics of a nervous disease known as *Chesu*, which corresponds in a remarkable manner to the malady known as *Latah* among the Malays.'[72] The typical comparative analyses made between African and European mental disorders, in this case, was directed elsewhere – toward Malaya where medical observation had previously supposed that *Latah* was 'confined to people of that stock.'[73] Latah was a syndrome thought to be triggered in an individual by some momentary fright such as a loud noise or an unexpected sight. The fright would then result in automatic behaviours such as repeating words (echolalia), a pathological imitation of another person (echopraxia), repetition of obscene words (coprolalia) and 'automatic obedience' such that one could give a command, 'jump!' or 'raise your hand!' which would prompt an automatic, involuntary response.[74] While generally believed to be confined to the 'Malay stock' by most scientific observers, George Beard, the neurologist who first described neurasthenia, documented a similar trance-like phenomenon occurring in remote areas of the eastern United States and Canada. Beard's article on the 'Jumping Frenchmen' of Maine (1880) described the involuntary jumps, word repetition and automatic imitative behaviour of a group of lumberjacks.[75]

Latah was often thought of in tandem with another syndrome, *amok*, as representative of the idea that different cultures or races experienced mental disorders that were unique to them. The term 'running amuck' has a long currency in the English language, dating back to the mid-seventeenth century. Its appearance as a medical term appears in textbooks since the mid-nineteenth century.[76] Amok is characterized as a sudden, unprovoked panic and frenzy that often turns into a homicidal frenzy. The community often has a role to play in such cases. They restrain the 'amok', sometimes isolating him for several days, and when the condition passes the victim is said to return to normal. As both amok and latah were observed most frequently throughout Malaya, the appearance of the two disorders suggested that some forms of insanity (often temporary) were 'culture bound'. A more current understanding of such expressions, however, suggest that these 'folk illnesses' manifest themselves with certain seemingly automatic behaviours precisely because the individual's understanding of their illness has been described culturally as encompassing certain behaviours.[77] Such classifications do not remain solely within the realm of biomedical description. In the United States, the folk description for the violent frenzy represented by amok is known colloquially as 'going postal'.[78]

## Psychiatry and difference

Comparative psychopathology by its nature presupposes difference and theorizes the reasons for such difference. Such observations were introduced to the psychiatric literature at the turn of the century with Emil Kraepelin's observations from Java which he titled 'comparative psychiatry.'[79] Kraepelin asserted that race remained a critical factor in comparative psychiatry, stressing that:

> If racial characteristics are reflected in a nation's religion and customs, in its spiritual and artistic achievements, in its political activity and in its historical development, they must also find expression in the frequency and clinical forms of its mental disorders.[80]

However, a more subtle and lasting point was his assertion that the psychiatric study of a nation could provide insight into its psychological make-up. Early in the twentieth century, psychiatry was proposing a new way of understanding political processes. Such assumptions about the psychological or often the psychopathological nature of political

activity and social movements, whether tied to race or more acceptably to 'culture', found frequent expression in East Africa. In the late 1940s the Colonial Social Science Research Council (CSSRC) took on the concerns surrounding the formation of African nationalist movements and African 'attitudes' toward Europeans. A group psychology approach was deemed necessary, although a memorandum on the 'Proposal for the Study of Colonial Nationalist Movements' cautioned against using social psychology techniques to the exclusion of historical, social and political factors.[81] Minutes from a meeting of the Council confirmed the agreement to pursue a study of 'African attitudes to Westernization on group psychology lines.'[82] Physicians and anthropologists weighed in with a number of proposals. Raymond Firth suggested a study of the social adjustment between educated Africans (and Creoles) and Europeans in West Africa. Isaac Schapera thought Mombasa would present a good field site for a study of 'the mental conflicts produced in some Africans by too rapid an onset of individualism.' Dr. Stanner emphasized the need for a 'study of intellectual and emotional resistance to administrative guidance, responses to European stimuli and other problems of communicating administrative purposes.'[83] As a foundation, previous research deemed useful for the new studies included Geoffrey Tooth's study of mental illness in the Gold Coast, the African marriage survey, and the Rhodes-Livingstone Institute's urban surveys from Northern Rhodesia.[84]

From the mid-twentieth century, anthropological and psychological academic interests in the production of ethnographies that documented exotic traits and habits, beliefs and lineages gave way to more modern analyses of social processes that no longer excluded the European from the environment under study. Under pressure to make sense of a rapidly changing environment of increasing labour migration and urbanization, economic stresses and inequalities, rising unemployment for African men, increasing land alienation, and the provision of, but then limitations to, education all coalesced to foster a social and political environment that saw not only traditional 'difference' but increasing psychological evidence of 'maladjustment' and pathology.

## The 'tropicalization' of scientific disciplines

Throughout the first half of the twentieth century, a 'colonial psychiatry' with its emerging expertise was intimately interwoven with developments in social anthropology and psychology. These disciplines grew in tandem with a general medical framework concerned

chiefly with tropical diseases and by extension, tropical peoples. Early psychiatric ideas about Europeans focused on lingering beliefs about the climate and the physical environment in the creation of the 'tropical invalid' suffering acutely from nervous sensitivities. However, when attentions turned to the African patient in British run mental hospitals, no African 'neurasthenics' could be found. The practical problem of culture-contact and acculturation, as both anthropology and psychiatry saw it, did not translate for Africans into nervousness, depressive syndromes or as chronic fatigue. The neuroses thought to plague civilized societies were noticeably absent as hospitals like Mathari began to chart diagnoses and publish statistics. Africans, particularly if they were male, were considered far more likely to suffer from forms of psychoses classed as mania, confusional insanity, or schizophrenia. Routinely physicians made a connection between African mental illness and explosive behaviours, not painful introspection. The image of the African exhibiting short bursts of excitement, anger or hysteria, such as had frequently been commented upon by administrators, was correlated with the African's greater susceptibility to psychoses and many generations of exposure to malaria and other tropical maladies. H.L. Gordon's proposition that 'it is by biological rather than social criteria that we are most likely to succeed in the great problem of raising the African native'[85] is illustrative of how the field of psychiatry saw its earliest contributions to the 'native problem'. After the Second World War strictly biological arguments that presumed innate difference held less sway and psychiatrists were more comfortable with the idea that Africans had adjusted physically to the tropical climate but were in an increasingly precarious psychological state as tropical Africa developed and became 'civilized' around them. Although biological differences between the races could not be shown, psychiatrists paid specific attention to neurological problems in East Africa, particularly those related to, or exacerbated by, conditions in the tropics.

Before the advent of the earliest colonial-run asylums, the early twentieth century ushered in shifts in thinking in both British psychiatry and neurology, as the two disciplines virtually exchanged disorders and classificatory systems. After 1900, psychiatry moved away from its stalwart emphasis on physical symptoms in the diagnoses of mental disorders, virtually reversing the trend of much of the previous century which saw physical symptoms as manifestations of pathologies of the brain. Victorian psychiatry had defined mental disorders 'as a morbid state of the whole organism, in which the operation of normal psychological

processes was impaired or suspended by the action of pathological physical processes.'[86] In contrast, neurologists were losing interest in disorders previously defined as 'functional' as they expanded their interests in the organic nervous disorders.[87] W.F. Bynum describes British neurology's shift very succinctly for the years leading up to the First World War:

> Neurologists' professional identities were much more closely bound up with the new precision in structural localization . . . The reflex hammer rather than the couch, the rest cure, or the talking cure had become their symbol.[88]

The 'reflex hammer', and the body of knowledge it came to represent, did indeed figure prominently within the diagnostic repertoire of colonial physicians who made frequent references to the tremors, jerks, convulsions, tics, ankle clonus[89], and automatisms of the Africans who appeared in their clinics or populated the mental hospitals. A frequently cited study of 2 years' worth of neurological cases appearing collectively at Mulago General Hospital and Mulago Mental Hospital in Uganda was published in 1944 as the first attempt to provide a systematic survey of neurological disease in East Africa.[90] Hutton conducted a similar survey for Uganda in 1956 and found similar associations between neurological disease and other acute infections.[91] The presence of neurological disease in the tropics dominated the literature on psychiatry generated in East Africa, but these conditions made a strong showing in the substantial journal literature on tropical diseases as well. Neurosyphilis, the complications from malaria, and epilepsy received frequent attention in East Africa and while these conditions were well known to physicians and were extensively documented in the general European medical literature, their appearance in a tropical setting prompted new ways of thinking about the 'organic' with implications about a neurological view of African social maladjustment.

East African physicians like H.L. Gordon contributed extensively to the medical literature primarily by adapting existing scientific theories to fit notions that he held close – generally those that fit into a eugenics and social hygiene framework. Ultimately, the psychiatric language generated from sites like Mathari was absorbed by colonial administrators in their assessments of individual African 'criminal lunatics' that migrated back and forth between colonial prisons and the mental hospital wards. The colonial government was concerned less with the often-sketchy details of psychiatric diagnoses, but did

utilize a broader body of evidence that seemed to justify the notion that the African population leaned toward mass instability. The use of psychiatric ideas, and specifically those generated from Nairobi, as a 'diagnosis' of the state of African social and political behaviour would find its most extreme application during the State of Emergency in Kenya and the highly influential government commissioned report *The Psychology of Mau Mau* authored by J.C. Carothers in 1954.[92]

## Conclusion

This chapter has been concerned with the emergence and transformation of key scientific and social science disciplines as they played out in East Africa during the first half of the twentieth century. The overarching framework provided by the intellectual migrations of the emerging 'tropical' disciplines of social anthropology, tropical medicine, and the under-resourced but influential 'East African school' of psychiatry helped to develop a larger body of evidence that would ultimately support East African colonial approaches to policy and governance. Problems long associated with the tropics, including questions surrounding European adaptation to the tropical climate, were not abandoned completely, but were re-invigorated as new research from the field. Social anthropology played an active role in formulating ideas related to adaptation and adjustment and provided a wealth of ethnographic data and theory that complemented the medical and psychiatric approaches to the intellectual problem of African behaviour amidst a rapidly changing social and political environment. The process of acculturation was one of the chief concerns of an academic anthropology that also sought to make contributions that could be deemed 'practical'. Concerns about acculturation found further expression in the medical and psychiatric literatures that theorized the reasons why Africans were predisposed to the negative effects of culture-contact, especially the deterioration of the individual personality and its associated mental breakdown of the collective.

British administrations became increasingly concerned with such academic questions as they attempted to predict the future social and political behaviours of increasing numbers of 'detribalized' Africans. Administrative departments concerned with the stability of rule across regions utilized data drawn from both anthropological studies and the British medical services. In turn, specialist interests such as those

concerned with African education also looked to the acculturation data in order to support more detailed theories about not only the progress but also the potential of the African in his various stages of social and psychological development.

Throughout the first half of the twentieth century, fundamental approaches to conceptualizing problems of governance were associated with ideas about the state of the African subject, not only socially and politically, but also physiologically and psychologically. John and Jean Comaroff have illustrated similar tensions using case studies from South Africa. Citing the imperial response to growing anxieties about labour, they assert that 'as blacks became an essential element in the white industrial world, medicine was called upon to regulate their challenging physical presence.'[93] There is no fault in this argument which could hold true for many other regions throughout the continent. However this is a more direct example of medically supported social control than the climate of ideas I wish to convey for East Africa. The 'challenging physical presence' at the heart of the Comaroff study is less pertinent here than the challenging intellectual and psychological presence presented by the East African population, particularly in Kenya. Scientific, and particularly medical, disciplines often operated along parallel lines. On the one hand, the Medical Services provided basic and clear-cut services in support of the European population and later to segments of the African population. However, medicine, even in times of depressed funding for all of the colonial departments, served an intellectual purpose in providing scientifically credible hypotheses and solutions for colonial problems.

In East Africa, the debate over civilization and mental disease, particularly for 'primitive peoples', replaced earlier debates on climate and mental disease concerned primarily with European adaptation. Such transformations were never absolute or complete, and in fact tended to recede and re-emerge in a cyclical fashion – the association between mental disorder and civilization pre-dates the nineteenth century preoccupation with climate. Environment as a force shaping mentality, mental processes, and mental abnormality remained as important as ever throughout the colonial period, but with the assistance of emerging professional disciplines in the tropical territories, the dangerousness attached to the African environment was transformed from nineteenth century climatic anxieties to post-War anxieties about an increasingly hostile socio-political climate.

## Notes

1. H.L. Gordon, 'The Mental Capacity of the African', *Journal of the African Society*, 33 (July 1934) 227.
2. J.H. Sequeira, 'The Brain of the East African Native', *British Medical Journal* (26 March 1932) 581.
3. Mathari Mental Hospital in Nairobi, Kenya is the hospital most identifiable with the 'East African School', however a small group of mental hospitals in East Africa also contributed to a body of literature that would appear in the *East African Medical Journal*. These hospitals included; Mulago Hospital in Kampala; the Zanzibar Lunatic Asylum (later Holmwood Mental Hospital); Mirembe Hospital in Dodoma, Tanganyika; and the mission-run Lutindi Mental Hospital in the Usambara mountains of Tanganyika.
4. This term is found both in the colonial literature and in the current historiography.
5. Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (London: 1995), p. 2.
6. An exception is H.L. Gordon who had training in neurology.
7. Megan Vaughan, 'The Madman and the Medicinemen', *Curing Their Ills* (Stanford: 1991), p. 107.
8. See A.B. Raper, 'Medical Writing in East Africa: The *East African Medical Journal*, 1924–1952', *East African Medical Journal*, 30, 8 (1953) 315–21. The *EAMJ* took its current name in 1932.
9. *A Note on Some of the Scientific Studies Undertaken by Members of the Colonial Medical Service During the Period 1930–47, with a Bibliography* (London: 1949).
10. Emil Kraepelin first defined dementia praecox in 1893, when he noted the progressive effects of dementia at a young age (praecox) following cases of mania or melancholia. The term evolved into what today is considered to be schizophrenia.
11. *Kenya Colony Medical Department Annual Report, 1933*, 32. The article to which this report refers is H.L. Gordon, 'Psychiatry in Kenya', *Journal of Mental Science* (January 1934) 167–70.
12. Kenya National Archives (KNA), BY/26/7: Industrial Health Research Board, ca. 1929.
13. A. Odonga, *The First Fifty Years of the Makerere University Medical School: and the Foundation of Scientific Medical Education in East Africa* (Kisubi, Uganda: 1989).
14. Lord Hailey, *An African Survey*, 1182–83, quoted in M. Semakula Kiwanuka, 'Colonial Policies and Administrations in Africa: The Myths of the Contrasts', *African Historical Studies*, 3, 2 (1970) 306.
15. Personal communication: Professor Alex Odonga, Kampala (7 August 2001).
16. Rhodes House Library (RHL), Mss.Afr.S.1872: H.C. Trowell, unpublished manuscript, pp. 9–10. Trowell published a number of texts and articles on African medical education taking place at Makerere Medical School in Kampala; H.C. Trowell, 'The Medical Training of Africans', *East African Medical Journal*, ii (1934–35) 338–53.
17. R.A.C. Oliver, 'The Comparison of the Abilities of Races: With Special Reference to East Africa, Part 1 & 2', *East African Medical Journal*, 9, 6 & 7 (1932) 160–75 & 193–204; Richard A.C. Oliver, 'Mental Tests in the Study of the

African', *Africa*, vii, 1 (1934) 40–6. Long after Oliver conducted his field work the question of African intelligence remained a subject for enquiry: J.M. Winterbottom, 'Can We Measure the African's Intelligence?', *Journal of the Rhodes-Livingstone Institute*, vi (1948) 53–9.

18. KNA, BY/26/7: J.H. Gilks to F.D. Keppel, Carnegie Corporation (4 March 1931).
19. KNA, BY/26/7: J.H. Gilks to A.T. Stanton, Colonial Office, London (28 May 1932).
20. The Kampala Meeting: Resolution on Research in Africa, *East African Medical Journal*, 13 (1936–37) 122.
21. Standard Correspondent, 'Mental Deficiency of East African Native – A Problem to Be Reckoned With in the Future', *East African Standard*, 16 November 1933; Unnamed Correspondent, 'The Study of Race Improvement – The Case for Scientific Research', *East African Standard* (21 July 1934), 36; Standard Correspondent, 'Causes of Native Backwardness – Necessity of Research', *East African Standard* (15 September 1934); Standard Correspondent, 'Backwardness of Kenya Natives – No Grant to be Made by Colonial Office', *East African Standard* (29 July 1935).
22. KNA, BY/26/7: Extract from Official Report of 29 November 1933, re: Africa (Native Education). Scott also published his own critique of the potential misuse of the cautious research of F.W. Vint; H.S. Scott, 'A Note on the Educable Capacity of the African', *East African Medical Journal*, 9 (1932–33) 99–110.
23. KNA, BY/26/7: H.S. Scott to Colonial Secretary, Copy of Minute (3 February 1934).
24. KNA, PC/Coast/1/1/175: Minutes of District Commissioners' Meeting held at Nyeri on March 8th & 9th, 1926.
25. A.B. Raper, 'Medical Writing in East Africa: The *East African Medical Journal*, 1924–1952', *East African Medical Journal*, 30, 8 (1953) 317.
26. J.C. Carothers, 'Frontal Lobe Function and the African', *Journal of Mental Science*, 97, 406 (January 1951) 12–48.
27. A recent Ph.D. dissertation addresses the interest in eugenics within Kenya; Chloe Campbell, 'Eugenics, Race and Empire: The Kenya Casebook' (Ph.D., University of London: 2001).
28. See C.S. Johnson and H.M. Bond, 'The Investigation of Racial Differences Prior to 1910', *Journal of Negro Education*, 3, 3 (July 1934) 328–39.
29. P. Rich, *Race and Empire in British Politics* (Cambridge: 1986) 102.
30. A.C. Haddon quoted in P. Rich, *Race and Empire in British Politics*, 104.
31. F.W. Vint's first article to utilize autopsy data recorded 176 post-mortem examinations on natives (1929), a 1937 study recorded 1000 autopsies and 27 different causes of death. See F.W. Vint, 'One Year's Post-Mortem Work on Natives of East Africa', *Kenya and East Africa Medical Journal*, 5, 12 (1929) 383–93; F.W. Vint, 'A Preliminary Note on the Cell Content of the Prefrontal Cortex of the East African Native', *East African Medical Journal*, 9, 2 (1932), 30–55; F.W. Vint, 'Post-Mortem Findings in the Natives of Kenya', *East African Medical Journal*, 13, 11 (1937), 332–40.
32. Public Record Office, Kew (PRO), CO 533/484/7: Prison Reform (Application for C.D.F. Grant) – Medical Aspects of Crime, 1937.

33. KNA, AG/32/74: Minutes of the Board of Visitors, Mathari Mental Hospital (29 April 1937).
34. J. McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: 1995), pp. 46–7.
35. Editorial, 'Dr. H.L. Gordon', *East African Medical Journal* (1937) 114.
36. Key examples of ethnographic work produced by Colonial officials include; C. Dundas, *Kilimanjaro and its People: A History of the Wachagga, their Laws, Customs and Legends, Together with some Account of the Highest Mountain in Africa* (London: 1924); C.W. Hobley, *Eastern Uganda, an Ethnological Survey* (London: 1902); C.W. Hobley, *Ethnology of A-Kamba and other East African Tribes* (Cambridge: 1910); C.W. Hobley, *Bantu Beliefs and Magic: With Particular Reference to the Kikuyu and Kamba Tribes of Kenya Colony; Together with some Reflections on East Africa after the War* (London: 1922); F.H. Melland, *In Witch-bound Africa: An Account of the Primitive Kaonde Tribe & their Beliefs* (London: 1923).
37. P. Rich, *Race and Empire in British Politics* (Cambridge: 1986) 108.
38. S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (Ithaca: 1985) 132.
39. Immanuel Kant, *Anthropologie* (1798) cited in G. Zilboorg, *A History of Medical Psychology* (New York: 1941) 308–11.
40. See Kant's earlier work (1764), *Königsbergische gelehrte und politische Zeitungen* cited in G. Zilboorg, *A History of Medical Psychology*, 308–9.
41. J. Goody, *The Expansive Moment: Anthropology in Britain and Africa, 1918–1970* (Cambridge: 1995), p. 192.
42. F.D. Lugard, 'The International Institute of African Languages and Cultures', *Africa*, 1 (January 1928) 2.
43. KNA, DC/EBU/5/4: Memorandum: Course of Anthropology (20 May 1913).
44. M. Fortes, 'Anthropological Training for Colonial Officials', *Man*, 46 (July/August 1946) 94.
45. L. Mair, 'What Anthropologists are After', *Uganda Journal*, 3, 2 (October 1939) 88.
46. B. Malinowski, 'Practical Anthropology', *Africa*, 2, 1 (January 1929), 23.
47. M. J. Herskovits, 'The Significance of the Study of Acculturation for Anthropology', *American Anthropologist*, 39, 2 (April–June 1937) 263–4.
48. B. Malinowski, 'The Anthropology of Changing African Cultures', xii.
49. A. Richards, 'The Anthropology of Changing African Cultures', in *Methods of Study of Culture Contact in Africa* (1938), 46.
50. B. Malinowski, 'The Anthropology of Changing African Cultures', in *Methods of Study of Culture Contact in Africa* (1938), vii.
51. B. Malinowski, 'Practical Anthropology', *Africa*, 2, 1 (January 1929), 28 (ftnt).
52. B. Malinowski, 'Practical Anthropology', *Africa*, 2, 1 (January 1929), 28.
53. R. Redfield, R. Linton, and M.J. Herskovits, 'A Memorandum for the Study of Acculturation', *Man*, 35 (October 1935) 145–8.
54. B. Malinowski, 'Practical Anthropology', *Africa*, 2, 1 (January 1929) 36–7.
55. B. Malinowski, 'The Anthropology of Changing African Cultures' (1938) xii.
56. A.T. and G.M. Culwick, 'Culture Contact on the Fringe of Civilization', in Bronislaw Malinowski, *Methods of Study of Culture Contact in Africa* (1938) 44.
57. S.F. Moore, 'Changing Perspectives on a Changing Africa: The Work of Anthropology', in R.H. Bates, V.Y. Mudimbe, and J. O'Barr, *Africa and the*

*Disciplines: The Contributions of Research in Africa to the Social Sciences and Humanities* (Chicago: 1993), pp. 14–15.

58. E.D. Tongue, 'The Contact of Races in Uganda', *British Journal of Psychology*, 25, 3 (January 1935) 357.
59. E.D. Tongue, 'The Contact of Races in Uganda', 357.
60. L. Lévy-Bruhl, *Primitive Mentality* (London: 1923).
61. In a lecture before the East African Branches of the British Medical Association in Kampala, H.L. Gordon coined the term 'bradyphysis' [brady=slow] to give a more 'scientific' name to what would normally be referred to as 'backwardness'. This was described as 'a non-progressive state showing deficiencies of physical, mental, moral, and social self-development according to the standards of a progressive people.' See H.L. Gordon, 'A Rumination on Research and Eye-Wash', *East African Medical Journal*, 13 (1936–37) 114.
62. KNA, PC/Central/2/1/11: Disintegration and Reintegration in the Meru Tribe, 9 (January 1940) 1–45.
63. KNA, PC/Central/2/1/11: Disintegration and Reintegration in the Meru Tribe, 9 (January 1940).
64. R.E. Park, 'Human Migration and the Marginal Man', *American Journal of Sociology*, 33, 6 (May 1928) 881–93. See also E.H. Ackerknecht, 'Psychopathology, Primitive Medicine and Primitive Culture', *Bulletin of the History of Medicine*, 14 (June 1943) 30–67.
65. R. Thurnwald, *Black and White in East Africa* (London: 1935) xviii. Thurnwald worked previously in New Guinea. The research in East Africa was supported by the Carnegie Foundation and the International Institute of African Languages and Cultures. See also, R. Thurnwald, 'The Psychology of Acculturation', *American Anthropologist*, 34, 3 (October–December 1932) 557–69.
66. R. Littlewood and S. Dein (eds), 'Introduction', in Littlewood and Dein, *Cultural Psychiatry and Medical Anthropology* (London: 2000) 10.
67. C.G. Seligman, 'Temperament, Conflict and Psychosis in a Stone Age Population', *British Journal of Medical Psychology*, 9 (1929) 187–202.
68. J.C. Carothers, 'Some Speculations on Insanity in Africans, and in General', *East African Medical Journal* (1940) 101–02.
69. B. Malinowski, 'The Anthropology of Changing African Cultures', in *Methods of Study of Culture Contact in Africa* (1938) xi.
70. L. Mair, 'The Place of History in the Study of Culture Contact', in *Methods of Study of Culture Contact in Africa* (1938) 4.
71. T.A.J., 'Book Review of *A-Kamba and other East African Tribes* by C.W. Hobley', in *Man*, 11, 39–40 (1911) 61–2.
72. T.A.J., 'Book Review of *A-Kamba and other East African Tribes*', 62.
73. Ibid.
74. R.H. Prince, 'Transcultural Psychiatry: Personal Experiences and Canadian Perspectives', *Canadian Journal of Psychiatry*, 45 (2000) 431–7.
75. G. Beard, 'Experiments with the "Jumpers" or "Jumping Frenchmen of Maine" ', in *Cultural Psychiatry and Medical Anthropology*, 35–7. This paper was given originally by George Beard at the American Neurological Association, 1880.
76. H.B.M. Murphy, 'History and the Evolution of Syndromes: the Striking Case of Latah and Amok', in *Cultural Psychiatry and Medical Anthropology*, 371–92.

77. R.C. Simons, 'Introduction to Culture-Bound Syndromes', *Psychiatric Times*, 38, 11 (November 2001). Although not solely concerned with the idea of culture-bound syndromes, Hacking's philosophical treatment of contested Western psychiatric disorders is instructive. See I. Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: 1995).
78. This term came into popular usage in the United States after a series of seemingly unprovoked and unexplainable mass murders involving a few individual postal workers who returned to their place of work and indiscriminately shot and killed co-workers and patrons. Similar cases occurred in other work places or in public spaces but the term 'going postal' became a common means of describing a uniquely American form of 'running amok'.
79. Kraepelin's term was 'Vergleichende Psychiatrie' (1904) and is today considered to be the forerunner to 'cultural psychiatry'. The article appears in translation as Emil Kraepelin, 'Comparative Psychiatry', in *Cultural Psychiatry and Medical Anthropology*, 38–42.
80. E. Kraepelin, 'Comparative Psychiatry', in *Cultural Psychiatry and Medical Anthropology*, 41.
81. Gunnar Myrdal's *An American Dilemma*, the 'historical–sociological study of the Negro problem in the United States', was considered by some to be an appropriate model for the study. G. Myrdal, *An American Dilemma* (New York: 1944).
82. PRO, CO 927/172/4: Use of Group Psychology, re: native attitudes toward Europeans (1948–50).
83. Ibid.
84. G. Tooth, *Studies in Mental Illness in the Gold Coast* (London: 1950); Arthur Phillips (ed.), *Survey of African Marriage and Family Life*, Published for the International African Institute (Oxford: 1953). The committee is most likely referring to Godfrey Wilson, 'An Essay on the Economics of Detribalization in Northern Rhodesia', Rhodes-Livingstone Institute papers, nos. 5 & 6 (Livingstone: 1941–42).
85. H.L. Gordon, 'Psychiatry in Kenya Colony', *Journal of Mental Science*, 80 (1934) 168.
86. M.J. Clark, 'The Rejection of Psychological Approaches to Mental Disorder in Late-Nineteenth Century British Psychiatry', in Andrew Scull, *Mad Houses, Mad Doctors and Mad Men*, (London: 1981) 278.
87. P. Koehler, 'The Evolution of British Neurology in Comparison with Other Countries', in F.C. Rose (ed.), *A Short History of Neurology: The British Contribution 1660–1910* (Oxford: 1999) 71.
88. W.F. Bynum, 'The Nervous Patient in Eighteenth and Nineteenth-Century Britain: the Psychiatric Origins of British Neurology', in W.F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry,* 1 (3 vols., London: 1985) 99.
89. Ankle clonus is defined as a muscle contraction most readily observed when the examiner bends the foot upwards maintaining pressure on the sole. It is usually an indication of disease in the brain or spinal cord. *Oxford Concise Medical Dictionary*, 2nd ed. (Oxford: 1998).

90. E.M.K. Muwazi and H.C. Trowell, 'Neurological Disease Among African Natives of Uganda: A Review of 269 Cases', *East African Medical Journal* (January 1944) 2–19.
91. P.W. Hutton, 'Neurological Disease in Uganda', *East African Medical Journal*, 33, 6 (June 1956) 209–223.
92. J.C. Carothers, *The Psychology of Mau Mau* (Nairobi: 1954). Much of this report is based upon a much larger study authored by Carothers in 1953 and published by the World Health Organization. See J.C. Carothers, *The African Mind in Health and Disease* (Geneva: 1953).
93. J. Comaroff and J. Comaroff, *Ethnography and the Historical Imagination* (Boulder: 1992) 216.

# 4

# The Microphysics of Power: Mental Nursing in South Africa in the First Half of the Twentieth Century

*Shula Marks*

> The asylum was to be a home, where the patient was to be known and treated as an individual . . . Mental patients required dedicated and unremitting care, which could not be administered on a mass basis, but rather must be flexible and adapted to the needs and progress of each case. Such a regime demanded kindness and an unusual degree of forbearance on the part of the staff. If this ideal were to be successfully realised the attendants would have to keep constantly in mind the idea 'that the patient is really under the influence of a disease, which deprives him of responsibility, and frequently leads him into expressions and conduct the most opposite to his character and natural disposition.' For this teaching to be successful and since the attendant was the person who had the most extensive and intimate contact with the patient, attendants should be selected for their intelligence and upright moral character.[1]

Over the last decade, historians have transformed our understanding of the racialised and gendered order of the asylum in southern Africa and of colonial psychiatry in the nineteenth and twentieth centuries.[2] Based on government and institutional documents, the writings of colonial psychiatrists, case histories and hospital registers, much of the small but growing body of recent work has been profoundly influenced by Foucault's understanding of the nature of power in the clinic and the asylum, and has examined the contradictions between the universalist discourse of European medicine, colonial psychiatric theory, and colonial asylum practice.[3] It has argued powerfully that in South Africa the discipline of psychiatry 'played a key role in legitimising . . . [a range of] interventions' to 'confine, regulate

and control disordered and deviant behaviour that might pose a threat to [white] society'.[4] Through psychiatric classification, it is alleged that patients were stripped of their identity.[5] At the same time, as racial, class and gender hierarchies were entrenched in the asylum by medical superintendents who were in the mainstream of contemporary scientific thinking, their theories of the undeveloped and primitive nature of 'the native mind' served to legitimate colonial racism. Rich and provocative, this work has provided an invaluable framework for understanding the history of psychiatry in South Africa and changing asylum practice in its social, political and economic contexts.

Given the sources, however, there is always a danger of mistaking the view from the top with the experience from below. As Julie Parle has cogently argued in her splendid thesis on the Pietermaritzburg Government Asylum (later the Town Hospital), Natal's first lunatic asylum, 'the reach of Western psychiatry' at least until the end of First World War, was tentative: far from being the dominant discourse,

> colonial psychiatry – which was closely associated with asylum practice – was of limited significance. More accessible and . . . far more acceptable, were the strategies and therapies that western biomedicine sought to displace . . . the adoption of biomedicine, including psychiatry, as a naturalised 'first choice' in the battle against madness, was as much the outcome of processes of historical change for whites in this region as it was for Africans and Indians.[6]

The limited status of psychiatrists and psychiatric knowledge even among white professionals is well illustrated by the minute number of murder cases referred for expert psychiatric opinion between 1910 and 1947.[7]

The emphasis on medical discourses and government policy also leaves out of account the crucial effect of nurses and attendants on the daily lives of the mentally disordered, and the role they may have played in 'stripping' the inmates of their 'identity'.[8] It is almost 20 years since Robert Dingwall, Anne Marie Rafferty and Charles Webster pointed out in their pioneering *Introduction to the Social History of Nursing* the history of nursing care for the mentally disordered 'probably has far more to say about the experience of patients than any study of medical sources'.[9] However, in South Africa as elsewhere the history of nursing care for the mentally disordered continues to be largely neglected in historical literature on the asylum. For all his influence on the literature of the

asylum, Foucault's insights have rarely been explored in relation to the 'micro-physics' of power in the asylum as expressed in the relationship between nurses and attendants and physicians on the one hand, and between carers and their patients on the other. Yet as Dingwall et al. conclude, 'In the old asylums with their handful of medical staff under a remote superintendent, the attendants would have had a critical role as intermediaries between the theories of the day and the ordinary life of the asylum.'[10]

If it is notoriously difficult to enter the world of the mentally disordered, and 'hearing the authentic voice of the mad African in written documentation really does involve straining the ears',[11] in South Africa it is as difficult to recapture the lives of the army of black people[12] who worked in its asylums, before the mid-twentieth century. And, perhaps somewhat surprisingly, we know little more of the daily lives of white mental nurses and attendants, even those working in 'white' institutions. Many of whom only come to our attention through acts of scandalous neglect or brutality, and the sometimes paranoid accusations of their patients. Nevertheless their quotidian encounters with the patients and the mundane daily terror and random violence of the asylum may have been more potent in stripping patients of their dignity and certainly had more to do with patients' well-being than articles in learned journals or the arcane case notes scribbled down at monthly, quarterly, annual and quinquennial intervals, by overworked psychiatrists as *aides de memoire* to themselves and their medical colleagues.

In this chapter, therefore, I attempt to address some fairly basic questions about mental nursing in South Africa in the first half of the twentieth century, before the introduction of psychotropic drugs and more professional nurse training, including professional training for black psychiatric nurses, began to change the lives of the mentally disordered. Focussing for the most part on Valkenberg Mental Hospital, it asks who were the nurses and attendants in South Africa's mental institutions in these years? Where did they come from? What were their duties? Were they trained and if so, how? What were their experiences of the asylum? What can one say about their encounters with the patients? And, finally, what if anything can they tell us of the experience of patients? The answers to these questions can only be tentative for the evidence is uneven and often fragmentary. The voluminous records of Valkenberg, the Cape Colony's first custom-built mental hospital, housed in the Cape archives, provide a useful but problematic starting point. They are exceptionally rich for the period between 1891 and 1911, when the institution was subject to the scrutiny

of the Cape's Colonial Secretary, but thereafter they change in nature. In the early years, the paper work of the asylum, and especially of its founding and first Medical Superintendent, Dr William John Dodds, was formidable.

For the historian, surveillance, *pace* Foucault, is of the essence. Meticulous record-keeping was clearly one of the ways in which the Cape Colony defined its identity as an outpost of civilisation and progress on the 'dark continent'. Dodds, an ardent disciple of William and Samuel Tuke, was determined to modernise the Colony's ramshackle asylums along the lines of Montrose Royal Infirmary in his native Scotland, where he had been Deputy Superintendent. Among his first actions, he replaced the earlier 'incomplete and haphazard' record-keeping of the Cape hospitals with case books for each patient and annual statistical tables which 'ensured that such details as age, marital status, occupation, religious affiliation, form of disorder and cause of insanity were kept for every new admission'.[13] And, whatever the surveillance of the patients, it was at least matched by the colonial state's surveillance over the asylum staff. From the outset Dodds had to inform the Under Secretary of the Colonial Office of all new appointments and promotions, resignations and dismissals, leave taken and wages paid. After the South African War, all new staff had to fill in questionnaires which included questions about their height, weight, age, marital status, previous employment, and religion. Nor was Dodds himself immune: 'Should not the policy of trusting responsible officials a little more, be tried?' he fumed in 1904 as he filled in the umpteenth form.[14]

In 1911, all the mental hospitals in the newly formed Union of South Africa were taken over by the central government and allocated to the Department of the Interior (together with prisons).[15] With the change of jurisdiction, the meticulous records of the colonial regime disappeared, a situation made worse by the destruction of asylum records in the Union's archives in 1948. After 1911, the sources on nursing in the asylums are far more diffuse and disparate – published annual reports of the Commissioner of Mental Hygiene; articles in the *South African Nursing Record* and newspaper accounts and letters to the editor; the fleeting unpublished records in national and provincial government archives; and what can be gleaned from extant case notes. The latter, so rich in other respects, has almost nothing to say about nursing care in the asylum.

There was a massive irony at the heart of the construction of Valkenberg as the very model of a modern asylum at the Cape, for it was also the first of South Africa's hospitals designed from the start to serve only the

white population.[16] Intended for 'recent and curable cases of insanity', the new institution was intended to signal to (white) patients and their families a wholly new approach to the treatment of the mentally disordered, far removed from the stigma of madness and the brutalities of its past treatment.[17] As 'race became an increasingly important marker of social and psychiatric difference during the last few decades of the 19th century',[18] Dodds saw the exclusion of black patients from the new asylum at Valkenberg as crucial if the stigma of mental illness were to be overcome – and a flow of paying patients ensured. In an age dominated by 'racial science', much of the accelerated drive for segregation also came from the 'progressive', scientific vision of the day, infused as it was by social Darwinist fears of white degeneration and black inferiority. Before 1916 when the first black patients were transferred from Robben Island to the Uitvlugt site adjoining Valkenberg, the records deal almost exclusively with white patients and, more immediately for our purposes, white members of staff. Valkenberg was hardly representative of the other asylums in the Cape Colony or for the rest of southern Africa: and, although, as we shall see, it fell far short of the aspirations of its founders and supporters, it was unmistakeably the least bad of the Colony's – and probably later South Africa's – public mental hospitals in the period covered here.

The building of the new Valkenberg in the 1890s was part of the 'major restructuring' of all the asylums in the Cape Colony between 1889 and 1908. Thus, with the establishment of Valkenberg, all white patients were gradually removed from the mental hospital on Robben Island. Situated off the shores of Cape Town, the Robben Island asylum was established as a 'general infirmary ... for lepers, "lunatics", and the chronically ill' in 1846, and continued to take the white male criminal insane until 1916, when some black mental patients also began to be removed to the Uitvlugt site adjoining Valkenberg, in an effort to solve the asylum's chronic shortage of labour.[19] The Grahamstown asylum (Fort England), initially established in 1875 for the chronic sick and indigent insane of all races, came in the 1890s to take only 'recent, acute and episodic cases of all races' (which meant in practice mostly white patients, especially as its Medical Superintendent, T.D. Greenlees, was more successful than Dodds at attracting a paying clientele); in 1908, like Valkenberg, Grahamstown also became an all-white asylum. There were two more asylums in the Eastern Cape: Port Alfred at the mouth of the Kowie River, opened in 1889, and initially took the indigent infirm and insane of all races, but was reserved for 'Coloured' patients only in 1908; Fort Beaufort was established in 1894, initially for black men

only; it acquired a wing for black women in 1897.[20] By 1908, then the racial re-ordering of the Cape's asylums was all but complete.

Given the failure of previous attempts to introduce moral management on Robben Island and the widespread crisis of asylums in Britain and the United States by the late nineteenth century, one can only marvel at the jubilation of Cape Town's city fathers at the building of Valkenberg Mental Hospital in the mid-1890s, and even more at Dodds's optimism that, if only he could catch them early enough, his (white) patients would prove curable.[21] Not surprisingly, the rhetoric soon outran the reality.[22] By the end of the South African War the new Valkenberg hospital, which had been launched with such high hopes in the previous decade, was already beginning to experience the shortfall in income and severe overcrowding which were to characterise most of its twentieth-century history – accounts of asylums elsewhere have shown a not dissimilar descent from the euphoria of the early days of individual asylums to their stagnation and decline. In 1913 on the eve of his departure from the Cape Dodds reflected that '... From 1905 the years had been simply black years. It is impossible to speak of the difficulties experienced from 1905.'[23] The problems of Valkenberg – again like its counterparts in Victorian Britain and the United States of America – were not confined to overcrowding and the deterioration of its built environment, however.

As in Britain, at least as important as increasing patient numbers and escalating bureaucratisation, the absence of cure and therefore the silting up of hospital space with chronic and congenital cases, was the shortage and resulting poor calibre of nurses and attendants. The shortage can only have been exacerbated by the colony's policy of employing only white staff. Thus in the years before Union, all the nursing staff, and most of the domestic workers, artisans and farm workers at Valkenberg – were white, although from the beginning, black 'convict labour' was also employed in the grounds of the asylum.[24] The same was true of staff in all the Cape Colony's mental institutions, except Fort Beaufort, where 'Coloured' (presumably African) assistants were taken on. Even this was 'an experimental measure' in response to Dodds's 'reiterated representations' that 'coloured assistants [be employed to] ... to act under European attendants' in order 'to lessen the cost of maintenance of the coloured insane', and in the face of the preference of the Colonial Secretary, J. te Water, for hiring white attendants. 'I recognise', te Water minuted on the correspondence, 'that there may be some saving. Notwithstanding I would only employ natives for the menial and dirtier parts of the work.'[25]

For all of te Water's zeal to protect jobs for whites, there was no great rush of local men and women to take up employment in the newly built Valkenberg asylum, despite its enthusiastic endorsement by the city's media.[26] From the outset Dodds found it extremely difficult to recruit suitable and sufficient local staff. The new asylum suffered severe staff shortages, and senior nursing staff were all imported from the UK, many of them from Scotland, recruited through Dodds's professional networks.[27] The first two matrons – Amelia Fraser[28] and M.G. Thomson – as well as the Head Nurse were probably all from Scotland, as were the Head Attendant and his senior colleagues. In addition, Dodds, like Dr Hyslop, the medical Superintendent of the Pietermaritzburg Government Asylum, was forced to bring British nurses and attendants on 3-year contracts to work in the hospital. At one point he was even reduced to importing an Assistant Cook and a Head Laundress from Britain.[29] Despite their travel expenses, the imported staff were generally better trained and therefore somewhat better paid[30] – and, equally important, less able to find alternative employment or return to their families when the going was rough – as it often was. As a result they remained in post for considerably longer than the majority of local women and men.

If qualified nurses of both sexes had to be brought from the UK, interesting ethnic and gender differences emerge in the pattern of asylum employment. Thus of the 90 or so nurses at Valkenberg between 1896 and 1907 for whom I have sufficient detail, about a quarter (22) appear to have Afrikaans names, and some 10 per cent seem to have been Irish.[31] Over a quarter (28) had some nursing, hospital or asylum experience, including all the contracted nurses: the rest came from usual upper-working and lower-middle class female occupations: dressmaking, waitressing, housework, seamstress, 'working for a tailor', but also clerk, typist, shop assistant, nursemaid. The solitary teacher who enlisted lasted 'only a few days'. Five were forced to resign owing to ill-health. As among male attendants the turnover was extremely high. Many did not stay more than a month or two, and the average length of service was less than a year. The Afrikaner nurses, with a couple of notable exceptions, remained for an even shorter time than most – perhaps because they had more local options or a family to fall back on. By 1907 10 of the nurses had received the certificate of the British Medico-Psychological Association, most, though not all, overseas recruits.[32]

By way of contrast, relatively few of the 130 attendants I tracked over the same period were not British or of British origin, a very considerable number of Irish and Scotsmen among them; many were recent

immigrants. Despite Dodds's efforts to recruit staff from the army after the South African War, he managed to attract only two or three men that way.[33] There was also a sprinkling of German and other European immigrants. Only 13 attendants had Afrikaans-sounding names – about 10 per cent. The far greater proportion of Afrikaner female nurses is perhaps evidence of the earlier proletarianisation of Afrikaner women than men, and the absence of more attractive or lucrative alternatives for women. It is also possible that, unlike many English speakers, Afrikaners did not automatically assume that asylum nursing was a man's work.[34]

The vast majority of attendants were, like the nurses, from the working and lower-middle class, apart from one salesman – the son of a 'well-to-do German merchant': gardeners, coach drivers, grooms, watchmen, labourers, soldiers, sailors, painters, tailors, and 'farmers'. Like the female nurses, many had minimal educational qualifications, and some found it difficult to spell. That a number of those presenting themselves for employment at the asylum possessed neither the inclination nor the aptitude for such work is evidenced not only by the rapid turnover of staff, but also by the not inconsiderable number of dismissals of attendants for drunkenness and insolence, as well as for acts of violence – often, to be fair, the result of considerable provocation.[35]

Thus 14 – just over 10 per cent – of the attendants were dismissed for being absent without leave, insubordination (one for calling the matron 'a two-faced bitch', which he later amended to 'a two-faced old cat'),[36] desertion, drunkenness, general unsuitability and assaulting patients. There were also a number of desertions: Attendant Tilley, for example, absconded after giving a month's notice in April 1903, with a 'suit of Government clothing for which he owed 15s and should also be required to pay 18s for leaving 6 days before expiry of notice.'[37]

As among the female nurses, the best qualified were specially recruited from British asylums, while a small number had worked on Robben Island or in the Old Somerset Hospital, which had a number of beds for the mentally disordered. Less than 10 per cent had or acquired certificates of the Medico-Psychological Association, or had any prior experience of nursing in an asylum or hospital. Dodds constantly complained of a shortage of 'men of the right stamp', and was frequently forced to seek permission from unenthusiastic local authorities to use his networks to recruit experienced staff from Britain.[38]

That the turnover of local nurses and attendants was so high is not entirely surprising. Wages were poor – in the 1890s white artisans

and clerks often earned considerably more than the attendants, while female nurses earned on average a third less than their male counterparts. Male staff had to get permission to marry and live off the premises: a privilege granted only rarely. As in the general hospitals of the time, nurses were expected to terminate their career on getting married. Despite almost a century of effort devoted to rescuing mental patients from the stigma associated with 'lunacy', 'moral treatment' had made little impact on popular opinion in South Africa. Dodds's attempts to attract better-off paying patients had been unavailing, and middle-class families remained reluctant to send their relatives to the asylum until they were too burdensome to manage at home, so that Valkenberg's inmates were for the most part poor, and often dangerous or demented.

As a result, the work of the asylum was, according to Dr Cassidy who succeeded Dodds as Superintendent of Valkenberg, 'arduous and exacting'; day nurses and attendants worked from 6.30 AM to 8 PM when the night nurses took over. 'Demented', 'stuporose', 'melancholic or resistive patients' had to be washed, dressed and fed in the morning and evening; wards had to be kept 'in a state of spotless cleanness'; nurses and attendants had to accompany patients on their walks twice a day – and be ready to apprehend any who tried to escape. Their reward was often 'bitter insults, degrading indignities, and cruel physical injuries'.[39] Under Dodds and his immediate successors, the penalty for the detection of any form of violence against a patient, however accidental or provoked, was dismissal: we have no evidence in this period of how much day-to-day petty violence by act or word remained undetected. At the same time, unlike the police, asylum staff injured by their patients in the course of their duties received neither pension nor compensation.[40]

The difficulties Valkenberg had in finding suitable nursing staff pale besides the problems incurred by Fort Beaufort and Port Alfred. In general it was even more difficult for hospitals in the more isolated rural areas to attract qualified staff, most of whom came from overseas, while local men and women were loath to look after the doubly stigmatised black and indigent insane.[41] Like Valkenberg, Fort Beaufort was rapidly overcrowded, while the work was often unpleasant and the wages poor. Quite apart from white stereotypes of the dangers posed by 'mad black men', the incidence of seriously disturbed and dangerous behaviour on the part of patients in the black mental wards was even higher than in the white, for in general rural Africans were justifiably even more unwilling than whites to allow the incarceration of family

members unless their behaviour seriously threatened the stability and well-being of the homestead. Even in urban areas, where African families may have found it more difficult to cope with the insane in their midst, they were generally 'reluctant to send mildly disordered and harmless persons to institutions'.[42] With the exodus of male staff who were attracted into the army by the prospect of higher pay during the South African War, the Superintendent at Fort Beaufort asylum, Dr Conry, was, as Swanson points out, 'hard pressed just to maintain the most basic standards of care to keep the asylum in any kind of practical working order.'[43]

In fact, even before the war, the shortage of appropriate attendants was acute. In May 1899, for example, Conry reported the escape of four patients who had been left in the charge of Attendant Du Preez who, in turn, had left 79 patients in the charge of three 'native Attendants (who have only just joined the Staff, and cannot understand English)':

> E.P. Du Preez cannot read or write, and cannot properly understand English, he has been sometime on the staff, but would not have been placed in charge of B Section if any Charge Attendant was on the Staff. The Asylum is so shorthanded that there is a great difficulty in working the place .... The Native Attendants are so careless and unreliable, that accidents, escapes and general neglect of patients is very likely to occur ....

The alleged 'carelessness' and 'unreliability' of the black staff may have resulted from the discriminatory wages offered to black staff as well as the tensions between white and black staff, as Conry intimated to the Colonial Office. He suggested that these problems could be resolved by engaging only African attendants and offering them better wages, which he justified on the grounds that the black staff were often better educated than their white counterparts. These proposals fell on stony ground, however.[44]

As a result, nursing 'care' in Fort Beaufort was often little short of scandalous, and often even the most basic attention was lacking. On 26 October 1899, before the war could have had much of an impact, Conry described a typical morning's ablutions:

> The night attendant generally gave patients over in the morning to the Head Attendant or a Charge attendant, and an ordinary attendant then proceeded to wash and dress them: I found that these requirements were done in a very careless manner, many of the patients I

> feel were not washed for weeks together, but were set to scrub the floors immediately they were dressed and never went near the lavatories . . . I asked the Head Attendant if these patients were washed, he said he thought they washed themselves in the scrubbing buckets and dried themselves in the bed sheets. I have altered the morning arrangements in such a way, that no other work is done until the patients have been washed, dressed and had breakfast.[45]

Nor was this all. 'Native attendant John, whom I have summarily dismissed, was in the habit of taking patients from the wards as soon as they were dressed, making them carry buckets from the dormitories outside and clean them, this was the scavenger's work, but under a mutual arrangement between him and the [white] head attendant, the patients did the work.'[46] As in the world outside, segregation was no bar to cross-racial collaboration among the criminally-minded.

In 1917, the matron of Valkenberg, Miss M.G. Thomson addressed the Western Province branch of the South African Trained Nurses Association in an explicit attempt to persuade the newly formed organisation to grant mental nurses the same status and recognition as general nurses.[47] In an attempt to sway her audience, Thomson extolled the changes that had taken place in mental nursing over the past few years. 'There is an awakening among mental nurses themselves', she averred. Not only were they better educated than ever before; but they were also encouraged by the frequent recovery of their patients. 'The old order of things is gradually passing away', she pronounced optimistically. 'The loafing attendant who just kept her eye on the patient, who did not exercise her mind, and only did as she was told, and often not even that, who remained for years in the hospital without attempting to pass her examination, these are gradually disappearing from the wards. The abominable words "asylum", "lunatic" "Attendant" and "cell" are struck from the vocabulary of mental hospitals . . . .', she concluded, while:

> The old pernicious system of having nurses sleep in rooms in close proximity to noisy patients, to be at hand in case of need, is not now recognised . . . as a necessity . . . Mental hospitals . . . are being run more and more like general hospitals, and in the larger mental hospitals in Scotland there is no difference to be seen . . . The high walls, enclosing a prison, are done away with, the wards are exactly like those in a

general hospital, and so are the nurses and their methods and the routine of work.[48]

Whatever may have been the case in Scotland, in South Africa there were few reasons for such optimism. Not only was Thomson blissfully unaware of what was happening in the asylums in which black patients were confined; over the following decades but also there was little improvement in the asylums even for white patients and their white carers. Valkenberg, which had opened with such fanfare in the 1890s, suffered from the shortage of resources, beds and staff along with the rest. Indeed in the 1930s Valkenberg and the Pretoria asylum were the most seriously overcrowded mental hospitals in the country.[49]

Under the Union's first Commissioner for Mental Hygiene, John Thomas Dunstan, four new hospitals for the mentally disordered had been opened,[50] but the number of patients under statutory care trebled. Moreover, even this limited hospital expansion came to an end after 1927, the result of financial constraints during the Great Depression and the general lack of interest in mental illness on the part of public and government alike.[51] As the regular complaints of successive Commissioners made clear, nowhere in South Africa did the number of beds keep pace with escalating numbers. And if the overcrowding in the white hospitals was 'serious' in 1932, Dunstan's successor as Commissioner for Mental Hygiene, Dr William Russell, believed that for 'natives' it was 'acute'.[52]

Although South Africa recovered relatively quickly from the world depression once the government decided to leave the gold standard in 1932, little changed for the asylums. During the worst years of the depression, it is true, rather more white nurses and attendants engaged for work in the asylums, including 'many who held matriculation and junior certificate qualifications'.[53] Training remained in the hands of the Physician Superintendents, however, and was in essence a form of apprenticeship, as it had been under Greenlees and Dodds 50 years earlier. The only change was that in 1932 the bilingual South African Medical Council took sole responsibility for the examination and certification in place of the British Medico-Psychological Association, a sign that by this stage the majority of mental nurses and attendants were South-African born, and Afrikaans speaking, a reflection of the impact of the depression on poorer rural Afrikaners. Thus in 1933 at Valkenberg there were 55 male nurses (including charge nurses) and 25 male pupil nurses at the hospital; (going by the surnames)

there were, conservatively, 22 Afrikaans-speaking male nurses and 22 Afrikaans-speaking male pupil nurses. Of the 15 charge nurses, nine had clearly Afrikaans-sounding surnames; the Head Male Nurse also was an Afrikaner. The proportion of Afrikaans-speaking female nurses was even greater: at least two of the three matrons had Afrikaans names, as did eight of the 15 sisters and no fewer than 27 of the 29 nurses and some 53 of the 63 pupil nurses, probably as a result of the depression, although as we have seen, even during the early years at Valkenberg there was a higher proportion of Afrikaner nurses than attendants on its staff. While the domestic staff had overwhelmingly Afrikaans surnames, by this time they probably belonged to brown Afrikaans-speakers.[54]

If overall staff numbers improved during the depression, this did not last long. When the economy improved, a result of the government decision to abandon the gold standard at the end of 1932, many who had been forced into asylum nursing for want of an alternative left, as did those with a 'good standard of education' and who therefore had some choice in the job market.[55] 1932–3 and 1942 were the only years between 1932 and 1960 in which more than 100 students took their final examinations in mental nursing. If anything, the end of the depression marked a further deterioration in the asylums, as the abler nurses and attendants sought more rewarding and lucrative employment, and the Medical Council was forced to drop the entrance qualification for mental nurse training to Std VI (i.e. 7 years of schooling).

Yet the number of patients continued to escalate. A report of the Mental Hospitals Departmental Committee in 1937 revealed the quite shocking overcrowding in the mental hospitals by that date – and the consequences for both the patients and their carers. At the end of 1936 there were over 1500 patients in mental hospitals for whom there was no room 'on the basis of the space arbitrarily allowed in calculating accommodation.' The report continued:

> Remembering that the bed is 3 ft in width, the space between beds in the case of Europeans is 18 inches; in the case of non-Europeans the space between mats is a few inches ..... If one remembers that in some cases excitable and occasionally dangerous patients occupy these dormitories, it is not to be wondered at that in a recent instance a patient was murdered by a fellow patient in the next bed before the attendants could intervene. Incidentally this is not the only time such an occurrence has taken place. In the

> case of non-Europeans the position in some of the dormitories is really appalling. Patients are sleeping in absolute contact with one another not only shoulder to shoulder but feet to shoulder when patients are placed both transversely and longitudinally in the same dormitory. They really make a solid layer of humanity so that there is scarcely room to put a foot between sleeping patients.[56]

If the patients were desperately overcrowded, the accommodation for staff, especially the nurses was pretty squalid. The Committee found that:

> In several instances three nurses are accommodated in a room where the space taken up by the beds almost covers the whole of the floor area. In other instances nurses occupy what are known as 'single rooms', which are in effect cells intended for noisy, dirty or refractory patients . . . .

Already in 1913 the Select Committee on the Treatment of Lunatics found the accommodation provided for the mentally disordered 'insufficient and unsatisfactory'. In 1936 the Departmental Committee was forced to conclude that the improvements and additions which had been made since then had 'not only failed to keep pace with the increased requirements since become manifest, but in some instance have not even overtaken the needs which then existed . . .'[57] The war stopped any further expansion and, although the new and reformist Minister of Health, Dr Henry Gluckman, announced an ambitious plan for the expansion of mental hospitals immediately after the war this came to an abrupt halt with the National Party victory in 1948.

Under the circumstances, it is hardly surprising that the shortage of appropriate carers continued unabated. Hours were long, the work difficult and the pay poor. In 1948, shortly after the National Party victory at the polls, the biennial conference of the South African Nursing Association was persuaded by the 'increasing discontent in the Mental Nursing Service' to conduct a survey of grievances among the mental nurses and attendants. The responses indicated profound dissatisfaction over a broad range of issues of which the most important were the long hours – often 12 at a stretch, poor wages and conditions compared to those in the Provincial nursing service, and the lack of compensation for injury or free medical cover.[58] Among male attendants, most

of them Afrikaans speaking, there was a pronounced impatience with somewhat ineffectual attempts of the Nursing Association to address their grievances, with considerable tension over the female domination of the Nursing Association with its still predominantly Anglophone leadership.

It was not entirely the fault of the Nursing Association or the Nursing Council that their representations met with little constructive response: mental health was never a priority for South African government of whatever persuasion, and it was very far from the priorities of the new National Party government in 1948.[59] An investigation on behalf of the Nursing Council in 1950 showed that the situation had actually deteriorated since 1948, especially in relation to the inadequate – if not 'complete lack' of training received by student nurses. The report blamed conditions in the hospitals, especially the overcrowding (which it called 'shocking' in the black wards), for these difficulties: 'the wonder is that there are still people willing to work under such conditions', it remarked. In that year, although there were, nationally, 190 student mental nurses in the first year of training, less than half (82) were still there in the second year; in the third and fourth years the attrition was even more dramatic. By their fourth and final year – less than an eighth of those who started (22) were left. The handful who were left were either deeply committed – or incapable of finding alternative employment.[60] As student nurses constituted the labour force in the hospitals the shortage was critical. Officials held that hours could not be reduced and conditions improved until the nursing shortage was solved; the Nursing Council and Association concluded that 'the grave shortage of nurses will not be relieved until the conditions of service . . . are improved'.[61]

In the early 1960s Charlotte Searle, by that time probably the most prominent nursing educationalist, and member of the South African Nursing Council (SANC) and South African Nursing Association, was scathing in her assessment of psychiatric nurses' education: 'Modern methods of teaching and administration . . . are non-existent', she asserted. The system is purely 'haphazard', and 'merely forces the student into rote learning. This approach is inevitable in a system where the student nurse is regarded by the Public Service Commission merely as a lowly labour unit.'[62] The entrance qualification remained low: between 1952 and 1960 the majority of white student nurses on mental nursing courses had an educational level below Std VIII. Very few (fluctuating from 83 to 2.16 per cent) had completed 11 years of schooling (matriculation) or entered the mental hospitals from general nursing

(from 5.8 percent to 3.07 per cent): hardly enough to provide for future matrons and senior staff. According to Searle, given free schooling for whites, when white children left school before Std VIII it generally indicated:

> ... lack of mental ability in the child or lack of social stability of the family. Either of these factors make the school leaver an unsuitable recruit for ... the care of the mentally ill ... The nursing function consequently deteriorates into a custodial function with resultant retardation in the recovery rate of the patients ... [and it] is therefore, a matter of national concern that the general educational level of the recruits to the mental nursing service is so low.[63]

Although the pass rate in the examination was generally over 70 per cent, the wastage in the first couple of years of training amounted to over 80 per cent: the high turnover that had characterised nursing care in the early years of the century was unchanged.[64] In 1960 Searle summed up the situation as follows:

> Mental nursing education has made no progress since the beginning of the twentieth century. On the contrary, there has been a deterioration in the general standard of education of entrants since that time, with only slight signs of revival in recent years. The administration of the nursing schools and the teaching methods employed are still those of the last century.[65]

From the 1930s the shortage of senior staff was exacerbated by the insistence of Afrikaner nationalists on a policy of strict bilingualism – which limited the number of overseas mental nurses able to work in South Africa – and by the refusal of the government to countenance the training of black nurses and attendants. The state was no more interested in making the 'organised endeavour ... to obtain educated non-European males and females for training in the care of mental patients ... on the general lines of that given to non-European females in several General and Mine Hospitals in the Union' as recommended by the Departmental Committee in the 1930s than the Cape colonial state had been before 1910. During Second World War, however, when Valkenberg was once again faced with the shortage of white staff, the Hospital Board noted with approval the employment of African male nursing assistants – and was 'impressed by ... their apparent efficiency'. It expressed its 'special satisfaction' that they not only resided

in the hospital but they also attended lectures – the implication being that by that time this was no longer true of white nursing staff – and the Board recommended the extension of the scheme to 'Non-European female Attendants on the same lines.'[66] This would appear to have been a localised experiment, and was only for 'nursing assistants' in any case. Immediately after the war, when the Minister of Health, Henry Gluckman announced more wide-ranging plans to reorganise the Union's psychiatric services, for the first time the Department of Health announced its intention to train coloured and African mental nurses and attendants to resolve the chronic shortage of nurses in the Union's mental hospitals.[67] In the event, the fall of the Smuts government put an end to these schemes. And although there were recurrent calls for the training of black men and women in order to release white attendants and nurses to address the acute shortage of staff in the white mental hospitals, it was only in 1956 that the first black men and women began training as psychiatric nurses – and the 1960s before any qualified. Ironically, unlike their white counterparts, the majority had the Std VIII Junior School Certificate (i.e. 9 years of schooling), while some had even passed their Std IX and matriculation examinations.[68]

Had Dr Dodds returned to Valkenberg in 1950 he would doubtless have recognised the source of its problems, but been horrified at their scale. In that year an inspection of the hospital carried out by the South African Nursing Council found that 'the usual degree of overcrowding exists, and as usual the worst conditions exist in the non-European wards'.[69] At the same time the hospital, by this time serving as the base for psychiatric teaching to medical students at the University of Cape Town's Medical School and a training school for mental nurses, had 61 unfilled nursing posts, and only attracted 18 female students: 16 in their first year, two in the second and none in the subsequent 2 years. As a result, at night 500 white female patients were cared for by one sister, one staff nurse and three student nurses; student nurses were expected to go on night duty every 3 months. No fewer than five nurses had contracted TB – a high-risk disease for overworked and ill-housed nurses in a country where the disease was rampant.

According to the Nursing Council, it was hardly surprising that this hospital suffered from so severe a shortage of nursing staff: the facilities for nurses were, 'quite frankly, appalling'. The Nurses' home for trained staff was 'dingy and depressing'; other nurses' quarters were 'scattered in various parts of the hospital', in rooms over and attached to wards,

or in 'extremely small cubicles, cramped, dingy and depressing' partitioned off from the wards. 'Coloured maids' – in effect assistant nurses – had 'shabby and poorly furnished' rooms in a specially built section near the 'Non-European' wards, having vacated their original quarters so that the white nurses working in these wards could inherit their rooms, which were also described as 'very small and dingy'. The accommodation for student nurses was 'the worst yet seen by the inspectors: there were hospital wards cubicled with only half walls, dingy, depressing and comfortless, lavatories without doors, and in one instance two facing with no door or attempt at partition'. The staff sitting room was 'being used as a store room' so that nurses had to use the dining rooms instead. 'The acute shortage of staff has in itself made nursing training a farce' the SANC report continued:

> Nurses cannot be released from the wards to attend lectures. Lectures are, therefore given when staff are off duty – and it should be remembered that they are on duty from 6.30 a.m. to 6.30 p.m. with only 1¾ hours off in that time for breakfast and lunch. Clinical demonstrations cannot be given as nurses cannot be withdrawn from wards. . . . Demonstrations in practical nursing are given during the hours of duty but owing to staff shortage the duration of the lecture is only half an hour.

Frankly aghast at the conditions which existed for the training of nurses at Valkenberg, the inspectors were 'reluctantly compelled to recommend that recognition as a training school be withdrawn forthwith'.[70] While the conditions at Valkenberg were grim, they were little better elsewhere. Looking at the SANC inspection reports the Commissioner for Mental Hygiene, Pieter de Vos wrote resignedly to the Secretary of Health:

> We have been fully aware of this position for a long time and as long as Provincial Services compete and financially beat us in the competition with jobs which are more attractive and 'husband catching' for females, this defect will not be remedied. I told the NC the other day that if things so on as they are, Europeans will have to be nursed by natives and ultimately we will not even have European sisters.[71]

What impact did this parlous state of affairs have on patients? In the first half of 1950, a flurry of letters in the *Cape Argus*, Cape Town's evening newspaper, which led to a private enquiry by the

Secretary for Health, George Gale, has left some trace of what the hierarchies of power meant even for white patients – in this case white female patients – in mental hospitals and private nursing homes in the middle of the twentieth century. Black patients had to wait for an enquiry by the American Psychiatric Association in 1978 for the first account of the dreadful conditions in the black mental hospitals in South Africa under apartheid: though they had no access to the state hospitals, and arguably had only a glimpse of the true situation.[72]

The correspondence was sparked off in February 1950 by a letter to the editor from Mrs Susanna Maria Bleicher, herself a former mental nurse, in response to a call by Judge Lansdowne for more psychiatrists and psychologists in South Africa to transform South Africa's penal policy.[73] For Bleicher, the 'crying need' was for properly trained mental nurses, rather than for psychiatrists. Having nursed both at the Queenstown Asylum and in private mental homes, she averred that of the hundreds of mental nurses, sisters and matrons she had encountered 'the great majority ... have not the foggiest notion of mental nursing; their sole conception of their "duties" is that they should act as jailers to their patients'. As a result, she asserted, 'cruelty, mental and physical' was 'daily practised in mental hospitals and homes', on patients who had little redress. The latter were at the complete mercy of their nurses, their complaints generally 'put down to "delusions" or glibly lied away by nurses and sisters'. 'Apart from the taunting, bullying and totally unnecessary manhandling', she continued, 'I have witnessed unbelievable cruelty on the part of mental nurses towards their patients.'[74]

The letter was accompanied by an editorial in the same issue of the paper, summarising Bleicher's view that 'great numbers of mental patients are subjected to daily ill-treatment by nurses who are devoid of the special qualities of character as well as the scientific training that are required by this most difficult branch of their profession'. 'Few of us', it continued 'know anything about mental hospitals. In fact, the persistent illusion that there is something vaguely discreditable about mental illness tends to create a certain secrecy about the whole matter, one of the most unfortunate results of which is to place the patients even more completely in the power of those in charge of them.' Given the difficulties of nursing the mentally disordered and their vulnerability, the editor concluded, 'A good mental nurse ... requires ... qualities of angelic patience and of sympathy, understanding and self-restraint, far above the common', qualities which, Bleicher argued, 'are lacking in the majority of mental nurses in this country.'[75]

Perhaps because it had the added authority of a powerful editorial in one of Cape Town's leading newspapers, the Secretary for Health felt obliged to rebut Bleicher's observations on the following day, not only because they were 'grossly unfair in their reflection upon an able and devoted body of public servants' but also because it would cause ' "quite unnecessary distress" to patients' families'. In any case, Gale asserted complacently, there were elaborate safeguards against any ill-treatment of mental patients.[76] As he put it in a covering note to the minister, there were 'of course instances of mental nurses who maltreat their charges, but *they are exceptional* ... and there is an effective mechanism for dealing strictly with such lapses'.[77]

This was followed by letters both supporting and attacking Bleicher,[78] while Bleicher herself responded to Gale's 'sweeping statements', and his assertion that there were safeguards against the ill-treatment of patients. Only the nurses could know what goes on in the wards, she warned, because they have 'a bush telegraph', 'perfected through decades of experience' which warned them of impending visits of outsiders. Indeed, she ended rhetorically:

> not even the resident physicians are in a position to see behind the scenes in a mental hospital .... Dr Gale claims to have an 'intimate knowledge' of hospitals. I wonder if Dr Gale has ever been present when patients have been bathed dressed and undressed?[79]

The public debate led Gale to enquire further. In March, he and the Commissioner for Mental Hygiene, Pieter de Vos, met with Bleicher who had been invited to submit a statement, and in May her statement was witnessed on oath before an attorney.[80] A Mrs de V, who had been a patient in both public (including Valkenberg) and private asylums in the 1930s, accompanied Bleicher to the interview to corroborate her story; de V also submitted a signed affidavit detailing her truly horrendous treatment in these institutions, although she also paid tribute in it to the handful of nurses in Valkenberg who, through their kindness and attention, eventually helped her regain her peace of mind. A well-connected, middle-class woman with friends in high places and in government, de V could not be easily dismissed.[81] Nevertheless it is Bleicher's vivid affidavit which revealed the truly shocking treatment experienced in many of South Africa's mental hospitals and homes even by white patients in the mid-century.

In her five-page account, Bleicher detailed her experiences as a mental nurse in the Komani Hospital, Queenstown, a public institution, the

Homestead Nursing Home in Johannesburg, the Gables in Rondebosch and the Clarendon Nursing Home at Rosebank, all three private mental homes. In all, she encountered 'the same type of nurse, [and] the identical methods of "mental nursing"', which, she claimed, were 'universal'. From the beginning she was warned by the Ward Sister at Komani to learn to hold her tongue and lie about assaults on patients if she did not want to get into difficulty.[82] The matrons, she was told, had no time for nurses who told tales – so she had better shut up. Patients were called 'moedswillige vuilgoed' or 'moedswillige donders' [wilful trash/fuckers], and treated accordingly. Not only were they kicked and slapped but also:

> The patients in Ward E were undressed and made to undress themselves at the same time for bathing. It was in winter and bitterly cold. They had to stand, herded together on the cement floor, waiting their turn to be pushed under the showers or put into the bath. Some of the women were over 70, others over 90 years of age . . . .
>
> Many women, particularly the old ladies, slipped and fell on the wet cement when they were pushed by the nurse . . . . The invariable excuse of the nurses was that they had to make the patients hurry.
>
> A favourite method of getting the patients to move . . . was to pinch their breasts and pull the hairs of their genital organs. It was explained to me that all the patients were afraid of this.

Jewish patients were a particular target, and were habitually addressed as 'Jou verdomde Jood' [You damned Jew] but English patients did not escape – they were termed 'Jou vervloekte Engelsman' or 'Rooinek' [you 'accursed Englishman' or 'Redneck' – a common term of abuse for the fair-skinned English]. When Bleicher reported a particularly egregious fracas to the (Jewish) Acting Superintendent in the presence of the Matron, he replied 'I have not been in this game for ten years without knowing that something of the kind was going on. I have had reports from nurses before but never anything like this. It is time scientific mental nursing was introduced.'

However when, on his return from leave, she told the Physician Superintendent:

> . . . about the absolutely unnecessary cruelty of the nurses towards the patients, that the dressing and undressing of the more trying patients was left to other patients, with the result that patients bullied

> one another . . . the theft by nurses of patients' clothes and parcels of eatables . . . and of the effect on some of the more intelligent patients [,] Dr C's comment was 'But the people always have been unkind to one another, haven't they?'

Bleicher's affidavit also contained a vivid description of the way Sister C demonstrated how the nurses punished people who were 'too big for their boots'; 'you had damn well better watch out that we don't do it to you', she was warned.[83]

> Sister C . . . , Nurse V . . . and another nurse . . . held a patient, Mrs R . . . , down on the floor and Sister C . . . tickled Mrs R . . .'s genital organ until she screamed continuously and hysterically. Mrs R was still screaming when they let her go and pushed her out of the side-room. Sister C told me afterwards that she had phoned Dr R . . . , told him that Mrs R had become hysterical *'vir geen rede nie'* [for no reason] and obtained his permission to confine Mrs R . . . to a side-room . . . . Sister C added 'En nou weet jy hoe word dinge hier gedoen en pasop nou vir jou.' ['And now you know how we do things here, so watch it'] Mrs R was generally very quiet and hardly ever spoke.[84]

A Mrs N, a Jewess, who had lost a leg and whose hands were 'practically paralysed', was constantly taunted by the nurse who dressed her each day that she had had sex with Mrs N's husband three or four times the previous night – 'And you lie here with your leg off and your ugly old mug [jou lelike ou gevreet].' According to Bleicher 'The formula varied only slightly at times. It was considered a priceless joke.' Any sign of kindness was regarded as a waste of time, and Bleicher was ordered to 'leave the patients alone' and get on with cleaning and polishing.

It is almost impossible to do justice to Bleicher's affidavit without repeating it at even greater length than I have done. Yet as she remarked, 'To take a few examples at random can give no inkling of the daily misery and hopelessness of the majority of the patients in a mental "hospital" . . .'

What are we to make of the acts of wanton and blatant cruelty related in the statements by Susana Bleicher and Mrs de V? The dialogue and descriptions can only have been based on personal experience; and although they are by far the most detailed and circumstantial accounts, there are other episodes in the archival records which suggest that such episodes were not uncommon in the asylums. Much

depended on the leadership and vigilance of the Medical Superintendent. In the early days at Valkenberg, the smaller scale of the institution and the elaborate institutional records that were kept on all episodes of assault or use of 'mechanical restraints', as well as Dodds's own determination to curb any form of institutional or individual violence, probably kept some check on what happened in the wards. As the asylums grew in size, and the pressures on staff intensified, it is clear that standards slipped.

A recurrent theme over the years in mental health circles, in South Africa as elsewhere, was the advantage of employing female nurses rather than male attendants. As early as 1917 the matron of Valkenberg, M.S. Thomson, remarked on the benefits of using female nurses in the male wards. In 1923 the Pienaar Inquiry into allegations of the brutal treatment of patients by male attendants found that while assaults of a very serious nature committed on patients were relatively isolated, unnecessarily harsh treatment of patients was a 'very frequent occurrence', while 'the "hook" system is a common practice of almost daily occurrence in several wards'. The remedy, according to the Acting Superintendent of the hospital was 'the considerable extension of female nursing of male patients in institutions of this nature, with the provision of a small male staff to deal with epileptics having violent tendencies, really violent cases and criminal patients.' Similarly in 1936, the Departmental Committee on Mental Nursing Services also recommended that female 'European' nurses rather than male nurses should be employed 'wherever possible'. As many before it, it was 'much impressed by the tidier and more cheerful appearance of the patients as well as of the wards in units in charge of female personnel' and 'the superiority of the care given to patients by female staff' and believed that the 'type of male European who applies for employment as a nurse in mental hospitals is not good'.[85]

In fact the Department of Public Health was no more successful in attracting suitable white women into psychiatric nursing. Although the brutality of male attendants has long been part of the litany of criticism directed against male nurses by a female nursing sorority jealous of its gendered monopoly, the grim story revealed by Bleicher and de V suggests that there is not much evidence to support the view that male attendants were invariably harsher than their female counterparts. Indeed the women described by Bleicher and de V seem to have devised particularly vicious yet insidious ways of asserting their authority over patients through humiliation; and fellow staff who stepped out of line

were at serious risk of victimisation. With this form of brutality there were fewer bruises or scratches to show at patients' weekly medical examinations.

Although her main interest is in the ways in which 'unobtrusive violence' was done to patients through modes of psychiatric classification, Sally Swartz has argued that 'violence in asylums was unavoidable, not only because of the effects of insanity on some patients, but also because stripping persons of their "outside" identity, and their actions of meaning, brutalized them, making violence to themselves or others – one of the few means of expression available.' Even more germane to our purposes she continues, 'to nurse people stripped of personal identity was brutalizing in the sense that it erased the possibility of interpreting "insane" acts as intrinsically meaningful. This was particularly the case with the black insane.'[86]

Equally brutalising, however, was the fact that the desperate overcrowding of patients, and the paucity of staff, their 'appalling' living conditions, lack of adequate training and lack of status meant that nurses were themselves under tremendous pressure, although we have little way of knowing what personal experiences of abuse, violence or humiliation lay behind the frustrations and barely repressed anger of the women who found themselves nursing in the mental asylums. A rare letter in the archives suggests some of the tension that could be found in the wards. In 1949 11 Afrikaans-speaking nurses at Sterkfontein Hospital, a relatively new, white and black institution in Krugersdorp on the Rand, left work en masse after one of their number, a Mrs M, had been dismissed with only 24 hours notice by the Medical Superintendent. The newly elected Nationalist Prime Minister, Dr D.F. Malan must have been somewhat startled to receive their letter denying the allegations that they had been incited to leave by the dismissed Mrs M, and setting out their grievances:

> We left because we are sworn at all day by Sister K, fuckers get your socks off and scrub the floor, you bastards.[87] Because Sister Dennis drinks with Mrs B. Because Mrs S slags [skel] us off all day. Because Mrs J V swears at us all day . . . Because when we tell Matron how we are treated then she says you can go if you like [jul kan maar loop] because you are only good for a sausage factory . . . you know what she means. Because when we are sick then the medicines we are given are made up by an untrained 'male nurse', his name is S . . . . Because [when] Dr J made Christmas for us the kaffer girls [meide] and kaffer staff served and he himself served [and] ate with them at

> one table. Further, white women patients expose their private parts in front of Coolies, kaffers and Jews. Furthermore we can never have an evening out because there is no bus and we have to pay 15/- for a taxi. We don't complain because Dr T [the Physician Superintendent] won't receive us and he is an Irishman and curses all Afrikaners.[88]

With little education and drawn from the least advantaged of the white workforce, the nurses were at the bottom of an often vicious and dehumanising pecking order in the hospitals. It is thus perhaps not entirely surprising that they took their frustrations out on their even more vulnerable patients. Although there were undoubtedly many self-sacrificing and caring mental nurses, violence in the asylum was no momentary aberration. Surely no better illustration of the 'microphysics of power' can be seen than in Susanna Bleicher's account of violence in the asylum, or the letter of the *elf verpleegsters*.

***

Moral management has often been seen as embodying Foucault's notions of internalised disciplinary power; the day-to-day experience of the patients, however, was intimately bound up with the physical invasion of their bodies. Their humiliation and violence served to reinforce the disciplinary power of the asylum, in stripping them of any self-respect, but the direct physical violations also served to frighten the mentally disordered into compliance, and led to the appearance and often the reality of intensified 'madness'. The relationship between sovereign and disciplinary power was intimate and dialectical, rather than sequential.

In every respect conditions for black mental patients were probably far worse, exacerbated by the racist attitudes revealed in this extract, linguistic and cultural misunderstandings, and the forms of racial persecution for which South Africa was excoriated in the later twentieth century. Black men and women were even less powerful than white women, who could on occasion rally powerful support from family and friends. Particular circumstances may then perhaps explain the pervasive culture of cruelty in South Africa's asylums in the mid-twentieth century, though gratuitous violence is a well-known feature of asylums as of all closed institutions. As Veena Das and Arthur Kleinman have recently remarked, 'subjectivity – the felt interior experience of the person that includes his or her positions in a field of relational power – is produced through the experience of violence . . .'[89] The atrocities in Abu Ghraib warn against any easy sense that we have left such inhumanity behind us.

## Notes

1. Andrew T. Scull*, Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (Harmondsworth: 1982)*,* p. 102, citing Samuel Tuke, *Description of the Retreat* (York: 1813), p. 175.
2. Megan Vaughan's chapter, 'The Madman and the Medicine Men: Colonial Psychiatry and the Theory of Deculturation' in *Curing Their Ills: Colonial Power and African Illness* (Cambridge: 1991) and her 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies* (hereafter *JSAS*), 9, 2 (1983), were the pioneering works. Since then, six theses have transformed our understanding of history of southern Africa's mental institutions over the last decade: Harriet Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846–1910' (Ph.D., Cambridge University, 1994); Sally Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape 1891–1920' (Ph.D., University of Cape Town: 1996); Felicity Swanson, ' "Of Unsound Mind": A History of Three Eastern Cape Mental Institutions, 1875–1910' (M.A., University of Cape Town: 2001); Lynette Jackson, 'Surfacing Up: Madness, Institutionalization and Social Order in Colonial Zimbabwe' (Ph.D., Columbia University, New York: 2001); Julie Parle, 'States of Mind: Mental Illness and the Quest for Mental Health in Natal and Zululand' (Ph.D., University of KwaZulu-Natal: 2004); and Tiffany F. Jones, ' "Disordered" States: Views about Mental Disorder and the Management of the Made in South Africa, 1939–1989' (Ph.D., Queen's University, Kingston, Ontario: 2004). I have drawn heavily on their insights. Although nurses and attendants receive some attention in these texts, their main concerns lie elsewhere. Only Lynette Jackson's thesis has been published.
3. Deacon, 'A History of . . . Robben Island' This is a central theme of her history of Robben Island's medical institutions, op. cit.
4. The quotation is from Swanson, 'A History of Three Eastern Cape Mental Institutions', p. 19; see also Swartz, 'Colonialism and the Production of Psychiatric Knowledge', passim. For my reservations, see Marks, ' "Every Facility that Modern Science and Enlightened Humanity have Devised": Race and Progress in a Colonial Hospital, Valkenberg Mental Asylum, Cape Colony, 1894–1910', J. Melling and B. Forsythe, *Insanity, Institutions and Society:* New Research in the Social History of Madness (London: 1999), pp. 268–91.
5. Sally Swartz, 'Colonialism and the Production of Psychiatric Knowledge', argues this throughout. See especially Chapters 4 and 7.
6. Julie Parle, 'States of Mind: Mental Illness and the Quest for Mental Health in Natal and Zululand' (Ph.D., University of KwaZulu-Natal: 2004), pp. 6–8.
7. Only 21 of the 3222 cases in the sample Rob Turrell analyzed over those years were referred to psychiatric experts for assessment; Robert V. Turrell, *White Mercy: A History of Murder and Rape in South Africa* (Westport, CT: 2004). This is not to say that psychological theories had no impact on criminology in South Africa. As Martin Chanock has shown, 'arguments based upon a genetic mental degeneracy linked to crime . . . flourished in a fertile South African soil', and these ideas could be found in policy, political and popular debate. (M. Chanock, *The Making of South African Legal Culture 1902–1936* (Cambridge: 2001), pp. 76–82. The quotation is on p. 76.).

8. In South Africa, as in Britain, female carers in the asylum were called nurses (even though most had no general nursing qualification and even fewer had asylum experience) and male carers were known as attendants.
9. Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: 1988), pp. 124–5.
10. Ibid. p. 125.
11. Vaughan, *Curing their Ills*, p. 102.
12. As always in South African history, racial terminology is both fraught and ambiguous. At the turn of the last century, contemporaries sometimes used the term 'Coloured' in the American sense of 'people of colour', both for people who would refer to themselves today as Africans (and who were more usually referred to as 'Natives' by the twentieth century) and for the people who are today referred to – and to a large extent call themselves – 'Coloured'; where the usage is not clear or would seem to refer to both groups, as here, I have used the term 'black'.
13. Sally Swartz, 'Changing Diagnoses in Valkenberg Asylum, Cape, 1891–1920: A longitudinal view', *History of Psychiatry*, 6 (1995) 433.
14. CO 7919, Memo by Dodds to CO 26 November 1904. In Britain, the keeping of case records was made compulsory under the 1845 Lunacy Act, although by then case notes were already in use in all the Scottish Royal Asylums. As Jonathan Andrews has pointed out, 'Besides their use for internal oversight, they were clearly being seen as a prime means of ensuring external scrutiny.' (Andrews, 'Gartnavel Royal Asylum' in Melling and Forsythe, eds. *Insanity, Institutions and Madness*, p. 258). The Scottish influence on South Africa's provision for the mentally ill, and on its legislation, was profound.
15. Mental hospitals were only transferred to the control of the Union's Department of Public Health in 1943.
16. R.C. Warwick, 'Mental Health Care at Valkenburg Asylum 1891–1909; Aspects of its Origins and Operation' (B.A. Hons. thesis, University of Cape Town, 1989), p. 31. Until this time, mental hospitals in the Cape Colony accepted the mentally ill, black as well as white, even if wards were segregated in a fairly unsystematic way, and there tended to be segregation too in dining and washing facilities. Harriet Deacon has usefully distinguished between the exclusion practiced by Valkenberg and the segregation of patients elsewhere. See Deacon, 'A History of the Medical Institutions on Robben Island', passim especially Chapter 5.
17. CO 1488, Under Col Sec to Med Super VH, 7 March 1891, talks of 'recent and curable cases'. CO1488 Dodds to Under Colonial Secretary, 10 March 1891, appears to make the elision between 'recent and curable' and 'European' for the first time.
18. Deacon, 'A History of . . . Robben Island', p. 113.
19. According to the 1913 *Report and Minutes of the Select Committee on the Treatment of Lunatics* (UG SC 14–13. CT 1913), ' . . . there is no valid objection to the maintenance on the same Asylum Estate, and under one administration, of patients drawn from both the European and the Coloured [i.e. black] sections of the population, provided they are housed apart and not brought into contact when undergoing treatment or at meals or entertainments; but . . . on the contrary, considerable economy can be expected inasmuch as suitable patients can be employed with advantage, both to the State and to

themselves, on work on such Estates, which in the ordinary way would be performed by hired Coloured labour.' (p. v).

20. This paragraph draws heavily on the overview of the development of mental asylums in the Eastern Cape, in Swanson, 'Three Eastern Cape Mental Institutions'. (the quotation is on p. 2); also H. Deacon: 'Remembering tragedy, constructing modernity: Robben Island as a National Monument' in S. Nuttall and C. Coetzee, eds *Negotiating the past: The making of memory in South Africa* (Cape Town: 1998), p. 173 and more generally her 'A History of... Robben Island'. See also M. M. Minde, 'History of Mental Health Services in South Africa. Part III: The Cape Province', *South African Medical Journal* (2 November 1974) 2230–4.
21. For previous attempts to implement 'moral management' on Robben Island, see Deacon, 'History of... Robben Island', passim.; for the sense of crisis in Britain and America, see, for example, Scull, *Museums of Madness*, pp. 194–200, 208 ff and Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: 1997), pp. 46–7.
22. For accounts of Valkenberg from 1891 to c. 1920, see Swartz, 'Colonialism and the production of psychiatric knowledge', Warwick, 'Mental Health Care at Valkenburg Asylum', and S. Marks, "Every Facility that Modern Science and Enlightened Humanity have Devised": Race and Progress in a Colonial Hospital, Valkenberg Mental Asylum, Cape Colony, 1894–1910', J. Melling and B. Forsythe, *Insanity, Institutions and Society*, pp. 268–91.
23. SC 14–13. *Report and minutes...*, p. 4.
24. CO 1488 Dodds to Col Under Sec 18 March 1891 'At Present 10 Convicts are Working on the Estate and Assisting in the Garden'. The asylum continued to use convict labour into the twentieth century. At the Natal Government Asylum in Pietermaritzburg, Dr Hyslop employed both African and Indian assistants to take care of black inmates, and did so 'with advantage' according to Dodds (CO 7177, Dodds to UCS 8 May 96).
25. The quotations are from the correspondence and minutes in CO 7177, between Dodds (as Inspector of Asylums), the Lay Superintendent of Fort Beaufort Asylum and the Colonial Secretary's office about the uniforms for coloured attendants at Fort Beaufort between 1 April 1896 and 15 May 1896. Dr Thomas NG. te Water was the MP for Graaff-Reinet. He was at this time in Sir Gordon Sprigg's third cabinet (1896–98).
26. See Marks, ' "Every Facility that Modern Science and Enlightened Humanity have Devised": Race and Progress in a Colonial Hospital', p. 274.
27. This was part of a longer tradition. Deacon, 'A History of... Robben Island', pp. 104–5, records that in the 1860s, as part of the reform of the RI asylum, additional staff were brought in, so that by 1871 it had more staff than any other colonial hospital. 'More of the RI staff were now Scottish immigrants who were considered more reliable workers than the Irish.' This changed as more male labour was attracted to the newly opened diamond fields.
28. There is some uncertainty about Amelia Fraser; according to Charlotte Searle, 'Amelia Fraser of the Grahamstown Asylum was awarded the first certificate [of the MPA] to be granted in the Cape [on 18 February 1893].... This launched the training of mental nurses in South Africa.' C. Searle, *The History of the Development of Nursing in South Africa, 1652–1960* (Epping, Cape: 1965)

117. According to Dodds's correspondence with the colonial office, Fraser came from the UK.

29. CO 7626/1099. She came out in 1897 and was paid £50 pa; this was raised in 1899 to £55 – because 'It is very difficult to obtain the service of a properly qualified Head Laundress' (Dodds to UCS, 10-10-99) .
30. In 1893 the pay for a nurse was £40 pa and upwards (compared to a male attendant of £50) plus board and lodging; the contracted nurses received a starting wage of £50, the contracted male attendants £75. According to Dodds, these rates were high: in British asylums, nurses were only paid £20 pa, Attendants £30 and upwards. **G. 16 –** 1995. *Annual Report of the Inspector of Asylums, Cape Colony, for 1894* (Cape Town: 1895), p. 158.
31. In the absence of this information or religious affiliation (which is only given in later records) one has to deduce ethnic origin from names. It can only be a rough and ready guide: many individuals with Irish or Scottish names were born in South Africa, and there was also a degree of intermarriage between English-speaking and Cape Dutch/Afrikaans settlers.
32. These records are scattered through the volumes of general correspondence between Dodds and the Under Colonial Secretary, so that it is easy to miss the odd name and my list is by no means complete. The above generalisations are based on data in the volume CO volumes in the Cape Archives: CO 148, 1527, 1576, 7178–9; 7331–5, 7388; 7424, and 7975–6; 7983.
33. CO 7179 Dodds to Col. Sec. 17 February 1902.
34. For the differential impact of proletarianization of Afrikaner men and women, see Belinda Bozzoli's seminal article, 'Marxism, Feminism and South African Studies', *Journal of Southern African Studies,* 9, 2 (1983) 139–71. The gendered Afrikaner and English assumptions about asylum nursing are hinted at in Searle, *History of Nursing*, pp. 118–9.
35. Fourteen in my sample of attendants were dismissed; only two of the nurses were dismissed, in both cases for acts of violence under considerable provocation.
36. CO 7179 Dodds to USCO 23 May 1902.
37. CO 7332 Dodds to Col Sec 10 March 1902.
38. See for example, CO 7179 Dodds to UCS 27 November 1897; CO 7331 Notes by Dodds on letters from the Under Colonial Secretary 3 and 5 February 1901; CO 7179 Dodds to Colonial Secretary 25 June 1901 and 17 February 1902.
39. C.G. Cassidy, Superintendent of Valkenberg, 'The Mental Nurse', *South African Nursing Record*, 5, 4 (January 1918) 84.
40. CO 7973 Minute by Dodds to UCS (3-1-07) on Letter from Secretary to the Law Dept., 31 October 1906.
41. Swanson, 'Of Unsound Mind', pp. 136–7.
42. UG 36–37 Union of SA: Report of the Mental Hospitals Departmental Committee 1936–1937 (Pretoria 1937), p. 10.
43. Swanson, 'Of Unsound Mind', p. 137.
44. Ibid. p. 138.
45. CO 7280 Medical Superintendent, Fort Beaufort to Under Colonial Secretary 26 October 1899.
46. Ibid.

47. In fact, trained mental nurses (but not attendants) were allowed to become members of the South African Trained Nurses Association from 1918 and Thomson herself headed the organisation 1923–5.
48. '"A plea for Mental Nurses", A Paper read by Miss Thomson, Matron of Valkenburg Mental Hospital, at a meeting of the WP Branch TNA', *South African Nursing Record,* 4, 11 (August 1917) 248–50.
49. UG 20–34. Union of South Africa. *Report of the Commissioner for Mental Hygiene. Statistical Tables 1930, 1931 and 1932* (Pretoria: 1934), pp. iv–vii.
50. New hospitals were established at Queenstown in 1922 and Fort Napier, Pietermaritzburg in 1927. In 1921 Alexandra Institute for the Feeble-minded established at Cape Town and the Witrand Institution for the Feebleminded at Potchefstroom in 1923. (UG 20–34. *Report of the Commissioner for Mental Hygiene*. p. iii). Dunstan was appointed in November 1916 and retired in April 1932.
51. According to a sub-leader in the Afrikaans-language newspaper, *Die Volkstem* (12 February 1937), the accommodation in the Mental Hospitals was 'equal to that of first-class hotels and that lavish expenditure is incurred on these'. Given the parlous state of the mental hospitals at that time – for whites as well as blacks – this extraordinary statement is more revealing of popular attitudes to mental illness than of reality.
52. UG 20–34, Report of the Commissioner, p. vi.
53. Searle, *History of Nursing*, pp. 314–15.
54. BC 1043 (UCT Valkenberg Papers) B3 'Valkenberg Mental Hospital. European Staff as at 31.7.33'. At this time, white English-and Afrikaans-speakers were roughly equal in number in the Western Province. The high proportion of Afrikaans-speaking students is particularly telling.
55. Searle, *History of Nursing*, pp. 315–7.
56. UG 36–37. Union of SA: *Report of the Mental Hospitals Departmental Committee 1936–1937* (Pretoria 1937), p. 7.
57. Ibid. pp. 7–8.
58. GES 2933 PH 3A Org Secretary. SANA to Minister of Health, 2 February 1949; GES 2935 PH 3 Registrar SANC to Minister of Health, 24 February 1949. GES 2935 SANC to Minister of Health 16 May 1950.
59. In 1945 £4,600,000 voted for the psychiatric services but in 1948 only £1,600,000. Leana Uys, 'Die Opleiding van Blanke Verpleegkundiges in Psigiatrie in die Republiek van Suid Afrika', D. Soc.Sci. OFS 1979, pp. 65–6. I am grateful to Professor Uys for showing me her thesis.
60. GES 2935 SANC to Minister of Health 16 May 1950.
61. *South African Nursing Journal* (July 1949) 18–19; GES 2933, DH Radloff to Minister of Health, 2 February 1949.
62. Searle, *A History of Nursing*, p. 314.
63. Ibid. p. 315.
64. Ibid. Table on p. 319.
65. Cited in Uys, 'Die Opleiding van Blanke Verpleegkundiges', p. 69.
66. BC 1043 B2 Minutes of the Valkenberg Board 1938- Minutes of a meeting of the Board on 26 January 1943.
67. GES 2327 145/38 Minutes of a speech by the Minister of Health to a meeting of the South African Council of Mental Hygiene held in the Town Hall, Bethlehem, 15 October 1946.

68. GES 2935 PM3 Part 2. Department of Health Mental Hygiene Section – 17th conference of physician superintendents of mental hospitals and institutions . . . 23–25 July 1956; Searle, *History of Nursing*, p. 315.
69. GES 2935 SANC to Minister of Health 16 May 1950. Extracts from the SANC Nursing Inspection Report are found in this correspondence, and are the source of what follows. The disaggregated figures for the excess of patients over beds were white: M 86 F 46; black M 160 F 153.
70. Ibid.
71. GES 2935, de Vos to Minister of Health, 24 March 1950.
72. Jones, ' "Disordered" States', Chapter 7, ' "Monopoly on Madness?" Private Long-term institutions in South Africa, 1963–1989', is the best account of the circumstances that led to the APA report and the nature of the enquiry and report.
73. Cape Argus 23-1-50 'Psychiatrists Needed. Judge's Plea for Mentally Ill'.
74. Bleicher, Gardens, 'Mental Nursing Reform', Letters to the Editor, *Cape Argus*, 1 February 1950.
75. Editorial 'Mental Nursing' in Ibid.
76. Cape Argus 2 February 1950, 'No Need for Public Concern. Charges Against Mental Hospitals Repudiated'.
77. GES 2935 PM 3B, Gale to Minister of Health, 2 Feb 1950.
78. See letters to the editor, Cape Argus, 6th, 8th, 15th and 22nd February. 1950. Also the private letter to Bleicher from ME Blackburn, 'a blind lady', Rondebosch, 9 February 1950, in GES.
79. Cape Argus 8 February 1950: 'Mental Nursing – Safeguards on Paper'.
80. Copies of statements by Mrs Susanna Maria Bleicher, 24 Orange Street Gardens, made on 19 March and sworn before an Attorney [no signature on the copy], Cape Province 22 May 1950; and by Mrs de V made on 2, 4, and 17th March and sworn before E.D. Tudhope, Attorney and Cape Commissioner of Oaths, 12 May 1950. What follows is drawn from Bleicher's statement unless otherwise indicated.
81. See S Bleicher to Dr Gale 12 March 1950.
82. 'Hier moet jy lieg dat dit so bars as jy nie wil in die moeiliheid kom nie. En jy moet van die staanspoor af leer om jou bek te hou.' Although the affidavit is in English, most of the dialogue reported is in Afrikaans; this is not surprising as by this time the vast majority of nurses and attendants were in fact Afrikaans-speaking. 'Hou jou bek' is particularly pejorative as 'bek' is an animal's mouth. It is closer perhaps to 'shut your trap' or 'shut up' than 'hold your tongue'.
83. The Afrikaans original is 'wat te groot is vir hulle skoene', and 'Jy moet verdomp oppas dat ons dit nie aan jou doen nie'.
84. 'for no reason' and 'now you know how things are done here and now watch out for yourself.' Italics in the original.
85. *Departmental Committee*, p. 20.
86. Swartz, 'Colonialism and the production of psychiatric knowledge', p. 95.
87. The original is 'Donder trek af jou kouse, bliksem, skrop die vloer'; 'donder' is literally 'thunder', but when used this way is a powerful term of abuse; 'bliksem' is literally 'lightning' but is, like donder, also used as a term of abuse. Here and elsewhere I am grateful to Drs June Bam and Wayne Dooling for enlarging my more genteel schoolbook Afrikaans vocabulary.

88. GES 2933 Copy: Letter in Afrikaans from 'Elf Verpleegsters' (11 nurses), Sterkfontein, Krugersdorp to PM, DF Malan, 10 March 1949. It is perhaps not accidental that the 11 unmarried nurses seem direct their venom against their married counterparts, and the Jewish and Irish psychiatrists. All the nurses (but not Sister D) had Afrikaans names, and the 11 nurses express themselves in a racy colloquial Afrikaans, hardly appropriate to correspondence with the Prime Minister. I have inserted some of the more colloquial Afrikaans phrases in the text.
89. Veena Das and Arthur Kleinman, 'Introduction' in *Violence and Subjectivity* ed. Das, Kleinman, Mamphela Ramphele and Pamela Reynolds, p. 1.

# 5

# Unsettled Minds: Gender and Settling Madness in Fiji

*Jacqueline Leckie*

Postcolonial studies have presented new perspectives to established narratives that emphasised the tangible material dimensions of colonial settlement.[1] Instead of narratives of guns and trade, more attention has been paid to what Edward Li Puma describes as 'power in the passive voice, the gradual Western saturation of medical knowledge and justice, the aesthetics of dress and the sociality of food, the conception of thinking and the representation of the body. Thus the everyday, the routines, the "givens" of everyday life.'[2] Colonial psychiatry encompassed both the coercive and more passive aspects of colonial settlement.

It may appear an exaggeration to describe settling disordered minds in Fiji as a systematic colonial psychiatry, because it was not until the 1960s that a government psychiatrist was appointed, prior to independence from British rule in 1970. In fact, Fiji has had a designated lunatic asylum since 1884, which still operates as a psychiatric hospital called St Giles.[3] The word psychiatry was rarely inscribed but the discourse of psychiatry permeated that of medical and legal authorities who settled Fijian minds.

This chapter unravels the settlement of disordered minds in one of Britain's smallest colonies. It then focuses on how the settlement of madness was gendered, building upon postcolonial scholarship that has linked power and settlement with reproduction, family and gender.[4] From commitment through diagnosis to treatment, the mad gendered body was the object that was worked on, both with regimes of moral management and more invasive psychiatry. Finally this chapter explores colonial psychiatry in Fiji concerned with a specifically female form of insanity, considered inextricably linked with women's bodies: the once common diagnosis of puerperal insanity. Although I trace the embodied

links between gender and madness in Fiji, this was not isolated from other subject locations, colonial hierarchies and ethnic boundaries in colonial Fiji. The asylum was a microcosm of Fiji's wider colonial, indigenous and immigrant populations, embracing different ethnic groups and classes, and including both the destitute and elite. Common to all was certification as insane and a madness that was strongly gendered and embodied.[5]

The chapter begins by setting the historical context in Fiji against which a lunatic asylum was established. It then outlines how the asylum was spatially and structurally gendered. Admission and outcome patterns for the asylum were gendered but equally striking were ethnic patterns. The body of the chapter concerns the gendering of madness discourse, considered through narratives of gender roles, constructs of madness, and especially sex and ethnic stereotypes, in which work and sexuality were embodied. The final section examines how treatment of the mind (whether control, care or cure) was primarily embodied in Fiji. To some extent Foucauldian theory and reworkings of this in the colonial context[6] inform this chapter, but equally important are constructions about madness and how unsettled minds could be calmed, emphasising localised discourse and available options of care and control.

## Settling Fiji and institutionalising madness

Fiji became a colony in 1874, during the zenith of British colonialism. The Public Lunatic Asylum was among the first institutions established in the colony. The demand for an asylum derived from civilising agendas concerned with both colonial settlement and the provision of medical care.[7] During the asylum's first year of operation only nine patients were admitted, among which were four 'homicidal maniacs'. This was hardly representative of Fiji's mentally ill. Once the asylum was established and legislation enacted to cover insanity, the number of insane patients increased, embracing more heterogenous mental disorders.

The asylum represented an extreme in colonial social control but hardly constituted a 'great confinement' as Michel Foucault postulated within European modernity.[8] The Fiji Public Lunatic Asylum was only one symbol of a colonial culture in which there were extensive laws regulating intimate details of subjects' lives.[9] It was the repository for a small number of severely mentally disordered subjects, classified as insane under statutory definitions of certification, albeit interpreted by lay, medical and legal judgements of normality. Mad subjects

were identified by both indigenous and colonial observers as highly disruptive to social order. The asylum also provided a space for some destitutes, providing food, clothing and shelter and protection from community ridicule and stigma. But conditions such as destitution, physical illness or family problems were secondary to the primary and common diagnosis as insane. Fiji's asylum was a site of confinement and treatment, physically adjacent to another modern custodial institution, the prison. The asylum was the destination of the 'sick mad' so consequently insanity in Fiji became linked with this institution.

The need for special accommodation for lunatics was first identified by the Police Superintendent in 1881 and reiterated by the Governor of Fiji, Sir George William Des Voeux in 1881.[10] Des Voeux reported to the Colonial Office about 'uncontrollable', mentally disturbed patients in the colonial hospital and suggested: 'A ward for lunatics, at such a distance that the latter might be out of hearing of the other patients, might be placed under the same management; in which case there would be temporarily supplied without much expense a want which is becoming much felt.'[11] The origins of the Fiji asylum were embedded within the early colonial extension of public health, policing, and prisons. The transference of modern medical care and control from Britain to its colonies was part of the control and regulation of colonial institutions and spaces.[12] Legal and social control became linked to the management of the insane. As with the early establishment of lunatic asylums in other colonies, there was an imperative to separate insane criminals from 'normal' prisoners.[13] Prison and especially medical authorities were reluctant to apply physical restraints to lunatic prisoners. Dr Blyth advocated moral management of the mentally ill when he warned in 1884 that the excessive use of mechanical restraints was counterproductive to the treatment and cure of mentally ill prisoners.

Financial considerations also determined the need to erect a separate space for insane prisoners. The Superintendent of Prisons, Mr Halkett, complained that his budget did not allow for the employment of sufficient European staff to provide 'incessant vigilance' over insane prisoners. Native staff were paid less but Halkett found they 'have been proved wholly unreliable in dealing with lunatics'.[14] The resources of European staff were considered over-stretched to be able to control both insane and normal prisoners.

Fiji had limited financial resources during this period but still meagre funds were allocated to build an asylum. The acquiescence of Fiji's local legislature and the Colonial Office to approve this during a period of

financial constraint may be because the asylum concerned not only prison management but also public health. Plans for an asylum were included with the draft for a new public hospital in Fiji's new capital city of Suva.[15] The driving force behind the establishment of modern health infrastructure in Fiji, including care of the insane, was Dr (later Sir) William MacGregor, Fiji's Chief Medical Officer between 1875–88, also Treasurer and after 1883, Colonial Secretary. He was appalled at the inadequate medical personnel and facilities in the colony and from 1883, recruited medical students from his homeland, Scotland, as well as founding the Fiji Native Medical School in 1885.[16] MacGregor had been a surgeon at the Royal Lunatic Asylum in Aberdeen and was Superintendent of the Lunatic Asylum in Mauritius.

Colonial settlement ushered in land, labour, economic and administrative policies that would have profound consequences for Fiji's future ethnic composition. The state attempted to restrict indigenous Fijians to the subsistence sector by bolstering chiefly hierarchies through indirect rule. Although indigenous Fijians were ostensibly protected under this civilising mission they still suffered social and mental distress. Meanwhile economic development proceeded with sugar production dependent upon the labour of around 60,000 indentured Indian immigrant labourers (*Girmitiyas*).[17] This displacement induced severe mental and physical trauma, requiring control and care. Harsh working conditions compounded the upheaval and living conditions on Fiji's plantations until new pressures emerged with the shift to small family farms from the 1920s. During these transitions women were essential in providing plantation, farm, domestic and reproductive labour. Europeans comprised a small but powerful group,[18] while other ethnicities that settled in Fiji included Chinese and other Pacific Islanders.

Colonial policies drew structural and discursive boundaries between indigenous Fijians, Europeans, Indians and other ethnicities, but there were several informal and institutional sites where these lines were blurred. The lunatic asylum, established in 1884, early in the history of Pacific colonialisms, was one institution where madness disentangled any ethnic divide. Fiji's lunacy legislation and the establishment of a lunatic asylum followed similar developments in the metropole and nearby settler colonies in New Zealand and Australia[19] and other British colonies, especially pertaining to gender. This was indicative of what Tony Ballantyne identifies as 'webs of empire',[20] which included linkages between asylums in colonial settings. However, unlike several other colonies[21] in Fiji, separate asylums were not erected for Europeans and

Natives. This was despite racial segregation within other institutions in Fiji, such as schools, residence and social clubs. As we now consider, gender, racial and class boundaries were reproduced within the asylum.

## Gendered space and infrastructure

Diana Gittins' spatial history of Severalls Hospital in Britain demonstrated the multiplicity of subject locations: 'Class, gender and categorising of illness were literally built into the hospital infrastructure and thus operated as primary determinants of power relations and a way of life.'[22] The history of St Giles also reveals how infrastructure reflected and framed multiple and hierarchical locations of gender, ethnicity and class. But gender was the principal spatial divide for patients at St Giles. This has almost always superseded the severity and categorisation of mental conditions, and in the past even racial locations. Initially however, the need for gendered spaces threatened colonial racial hierarchies.[23] In 1892, a Fijian woman had to be confined to the European women's building 'to save her from annoyance and physical danger caused by the male Indians and Fijians. This can only be done at the risk of the Europeans.'[24] By 1910, Fiji followed metropolitan and colonial practices of establishing separate accommodation in the asylum for men and women. In 1914, the asylum's Board of Visitors complained that the maintenance of racial boundaries was threatened by inadequate gendered accommodation; '. . . the expediency resorted to of confining, during the night, Native female patients in the female European Ward owing to insufficient accommodation could not under any circumstances be justified'.[25]

Throughout most of St Giles' colonial history racial locations were maintained with separate wards for European men, European women, Native men and Native women. Natives included *all* non-Europeans, that is mostly indigenous Fijians and Indo Fijians. 'Part-Europeans' were sometimes accommodated with Europeans, possibly because of kin connections. Not only were wards demarcated according to gender and race, but also the quality of accommodation was different. The European wards operated like homely cottages with better quality beds, soft furnishing and recreational amenities such as books and games. Racial distinctions were also reproduced through different food rations and clothing. These regulations were formalised in 1914 although it is not clear whether this had previously corresponded to racial or class divisions.[26] Not only did the asylum's infrastructure define gender, race and class locations for patients, but also for staff with different

accommodation, diet, clothing, pay scales, responsibilities and spaces for male and female doctors, male and female European and Native attendants, and male and female servants.

## Admission and outcome patterns: gender, ethnicity and poverty

Colonial settlement necessitated surveying and moderating intimate aspects of subjects' lives and bodies,[27] including madness. Available quantitative data relating to insanity in Fiji is incomplete, hardly objective and requires cautious interpretation.[28] It provides some context against which to trace gender and ethnic patterns and locate the quiescent histories derived from other testimonies. The richest source is a database I have constructed from admission papers covering 3129 admissions between 1884–1964. The official sanitised, summarised and public picture was recorded in annual reports of the asylum, and the 'Blue Books', reporting mostly through statistics, on the annual state of the colony. Precise details on the asylum included the cubic space/window space per patient, type and duration of restraints, diet, and nature and therapy of mental disorders. Such data was further located according to gender and ethnicity, all contributing to colonial knowledge and rule in Fiji.

Feminist literature has highlighted the links between women and mental illness,[29] but committal rates to asylums were not always as high as men's.[30] At St Giles women comprised between 20 and 50 per cent of admissions up to about 1930 but thereafter this gap gradually closed. Ethnic differences are more striking. After 1900 Indo-Fijians comprised the majority of female and male admissions. This is indicative of increased destitution among Indo-Fijians during the transition from plantation labour and the consolidation of family farm social and economic networks. Between 1919–23, Indo-Fijians comprised c. 66 per cent of first admissions, compared to Fijians making up c. 21 per cent. Other ethnic groups, including Europeans, accounted for one-fifth of the small number of admissions before 1900 but thereafter this proportion substantially declined. This is to be expected given that this demography was always a small part of Fiji's population.

Research covering, 1884–1933, found that among all first admissions with a recorded outcome, c. 47 per cent died in the asylum or hospital compared to 53 per cent who were discharged. Indo-Fijians comprised 50 per cent of these deaths, compared to indigenous Fijians accounting for c. 35 per cent. High death rates are not surprising given reports

of extensive physical disease among asylum patients during the early twentieth century. Mortality rates contained significant gender and ethnic differences. Men had worse mortality rates than women. This possibly reflects that some women may have been admitted with less acute mental distress but more noticeable violation of gender norms than many men. Such women possibly suffered less terminal physical illness or had already received medical care if their insanity was linked with childbirth. Most significant in disentangling the higher asylum mortality rates for men was the preference for women's early discharge if they were wives and caregivers. Mrs J's husband wrote a letter requesting her discharge only 2 months after her admission with puerperal insanity in 1896.[31] She was discharged the same day. But after readmission in 1905, older, widowed and presumably without dependent children, Mrs J remained at St Giles until her death in 1909.

Mortality rates were high for indigenous Fijian and Indo-Fijian patients. The highest mortality rates were proportionately among ethnic Fijians although Indo-Fijians constituted a higher percentage of total asylum deaths. The number of Fijians committed to St Giles between 1914–23 who died there was alarmingly high. Some were vagrants with severe poor mental and physical health such as a Fijian woman who had 'assaulted several people in town with sticks, tried to set fire to a house, refused all food for several days and wanders about at night, refused to work'. She died 6 months later in the asylum. This may reflect not only the extreme mental but also physical distress indigenous Fijians had reached before accessing state institutions. It poses questions concerning the availability and preference for community care and control, and aversion among Fijians to state medical institutions. High Indo-Fijian death rates were indicative of neglect during and after the abolition of indenture. The sad fate of two ex-indentured Indo-Fijians admitted during 1918 revealed the physical and mental deterioration behind these statistics. A male lunatic who had been living in the bush in Macuata district was described by police as having a 'wild appearance; neglected sores on body; disconnected stories; delusions as to devils persecuting him; clothes torn up'. A female 'mental deficient' was found crawling along the road. Within 8 months these patients had died at the asylum.

## Gendered discourse and madness

The gendering of 'madness' is striking, when the discourse of admission certificates and medical journals are examined. Classification as 'mad' operated at several levels in Fiji and was discursively and subject-

ively framed in different locations. Only a small minority of those considered mad by their communities became legally certified as insane and were committed to the lunatic asylum. Certification papers are the only remaining texts of this process and along with fragmentary archival material provide a glimpse into the categorisation of madness in Fiji. Historic, ethnographic and linguistic evidence indicates that local communities in Fiji accorded madness to those with repeatedly aberrant behaviour, outside localised norms of rationality. Indigenous and Fiji Hindi words for crazy were sometimes cited on medical certificates. Within both indigenous Fijians and Indian Fijians, diagnosis was integral to treatment and this was frequently connected with extensive spiritual or metaphysical states. Indigenous Fijians located madness within broader concepts of wellness and illness that were entwined with the community, spirit and ancestral worlds.[32]

In many instances the impetus to contain crazy individuals or hand them over to the care of the state came from kin or community. Certification required a doctor and a stipendiary magistrate to complete two committal schedules (or two doctors for private patients). As there were few district medical officers in early colonial Fiji, certificates were often issued in Suva. The doctors who signed these were ignorant about the patient's history and relied upon their immediate observations and reports from others. Such observations revealed how madness was identified and ultimately categorised. Evidence of madness was penned from a variety of sources including patient and family histories, observations and opinions of *Rokos* (provincial heads), *Bulis* (district heads), chiefs, ministers of religion, police, local magistrates, teachers and employers. By the time these observations were recorded for certification they may have undergone several reincarnations. The legal admission records, appeared to be foundational documents in the settlement of sanity and insanity. Instead legal certification as insane and admission to the asylum settled the demarcation of madness. Most admission records were filed away, were poorly preserved and many were not read until I began my research over a century later.

## Colonial stereotypes of gender and embodied madness

'Gender differences first appear in the perception of emotional distress itself....'[33] Lay and professional categorisation and diagnosis of mental illness were frequently grounded in cultural perceptions of appropriate gender identity and behaviour. The gendering of madness reflects socialisation and embodied experiences of this. The Fiji records explicitly

associate women's insanity with their emotional or reproductive lives. Despite early colonial debates over suicide and sexual jealousy among *Girmitiyas*,[34] relationships and sexuality were only occasionally linked with causing men's madness in the St Giles' records. Men's sexuality was commented upon but rarely morally judged like women's, with the exception of a few males diagnosed with 'masturbatory insanity'.

Men were more likely to have their madness caused by money or employment problems, organic illness or accidents, while women's madness was said to be precipitated by a love affair, infidelity, jealousy, 'matrimonial unhappiness', 'domestic troubles'.[35] Mrs J's second admission 1905 was attributed to shock from her husband's death and subsequent irrational behaviour; she 'jokingly alludes to serious subjects, for example, husband's recent death and funeral'. Although women were considered more susceptible to emotionally or relationally caused madness, this was embodied through behaviour and biology. Some records describe men going mad ostensibly from domestic crises but most of these texts refer to Indo-Fijians. Common causes of insanity for both men and women assigned during this period included old age, physical illness and syphilis, which was linked with general paralysis of the insane.

Patients' testimonies were often marginalised as mad performance that was animalistic, uncivilised or childlike. Insane people were not usually privileged with 'testimony' but spoke, screamed or garbled their 'delusions'. Histories of madness have tended to dismiss subject voices.[36] Roy Porter asserted that although '[t]he mad person's . . . immediate oppressors mainly existed only in their heads . . . they were commonly the analogues of ogres out there in society, in the culture'.[37] For example, was Dukhni's madness delusional or indicative of her corporeal world? She was diagnosed with mania 'since meeting her husband 18 years ago . . . Imagines her husband continually wishing to assault her'. A police officer stated that Dukhni had repeatedly made reports of assaults, which on investigation were false. Her violent world (that may have been actual, delusion or both) was also directed towards her husband. Immediately prior to her commitment she went to 'the police station with a knife saying if police couldn't find her somewhere to stay away from home she would chop up her husband'. The only record we have of actual violence is when she attempted to hang herself.

Tomes found in the United States that 'family members often cited sudden or extreme deviations from an individual's habitual behaviour, including departures from their normal sex roles, as evidence of mental disease – for example women who ceased to care for their personal

appearance'.[38] The St Giles records revealed similar trends, although men who deviated from norms, such as behaviour or appearance occasionally elicited comment. However with women the transgression was not just of 'civilised behaviour' but also of feminine norms, where appearance, comportment and deportment were emphasised. Dishevelment, lack of control, excessive mobility, and especially violence could be taken as signs of insanity. A female Indo-Fijian labourer committed to the asylum in 1925 was 'restless, loquacious, continual gesticulation; continuously in an insane manner; apparently no regard for her femininity; general demeanour that of a lunatic . . . runs about without clothes; throws away husband's food; burns her husband's clothes; fights with other women in the lines; has attacked another woman with a knife'.[39]

However madness was defined not only in relation to gender but also ethnic stereotypes and transgressions, and such evidence was primarily cast as observations about embodied appearance and behaviour. An admission certificate in 1920, cited as evidence of an Indian women's melancholia and insanity, that she was not clothed 'in accordance with the custom of Indian women'. Several observations that confirmed the insanity of indigenous Fijian women stressed transgressions of norms of gendered and ethnic appearance and behaviour, as in 1915, when a Fijian woman was considered by a doctor to have dirty habits in a way 'unusual among Fijians'. His assessment came from evidence supplied by a a Native Medical Practioner and a police officer: 'for a long time in her village she has been filthy in her habits, has been stealing trifles from numerous houses, and at times goes about naked'. Elsewhere Dr Harper, the District Commissioner and Medical Officer of the remote Lau islands, observed that the 'general behaviour, especially head gestures' of a Fijian woman 'express a boldness or sometimes lustfulness not usual in Fijians'. Her initial conversation with the doctor concerned 'her monthly periods, no exact meaning, but "no normal Fijian woman" mentions these unless asked or there is some corresponding disease'. In 1918 a Fijian official, a *Buli,* supplied evidence of another Fijian woman's insanity: 'Sees S. go to church with her clothes obviously soiled by her menstrual discharge.'

Work was a dominant trope within discourse concerning women's insanity, especially when women neglected domestic work. Amid lurid descriptions of Emily's 'delusions of a sexual behaviour, erotic statements. A man has gone to the colonies and a subscription should be raised to bring him to her', were reports that Emily had refused to work despite having a 'large family to look after'. Even when women engaged

in serious acts of violence their transgressions of everyday domestic duties also substantiated evidence of their insanity. In 1893, a Fijian missionary's wife was committed to the asylum after being '[f]requently violent with peculiar animosity against her husband. Threw her child down some time ago and thereby has injured its spine . . . Took a quantity of cooked and prepared food and threw it out to the fowl.'

Work role expectations in Fiji were framed not only by gender but also by ethnicity. Poorly paid and arduous work was normal for many Indo-Fijian women during the *Girmit* years. How do we read 'delusions of persecution' when a tearful female *Girmitiya* who was admitted to the asylum, claimed 'that her *sahib* and *sirdar* beat her and get angry with her', given the well-documented violence of indenture?[40]

European assumptions about masculinity and work were also problematic for indigenous Fijian men. Most were not waged workers so their insanity cannot be simply equated to transgressing Eurocentric masculine notions of work.[41] The sin of 'idleness' still applied to Fijian villagers, such as Rusiate in 1922, who was not only violent towards property but had 'consistently neglected all communal work for the last two years'. Indo-Fijian *Girmitiyas* who refused to work were accused of 'malingering'. Authorities were ambiguous over whether this was deliberate or beyond the workers' control because of insanity. In contrast European men who stopped working were clearly of 'unsound mind' such as a plantation manager who bathed his head in a creek and prayed all day instead of working.

Following Foucault's *History of Sexuality*, McClintock and Stoler[42] identified sexuality as a marker of colonised subject locations. This also applied to mad bodies especially where medical discourse concerning sexuality defined normal and pathological bodies and minds.[43] In Fiji, early asylum discourse centred on women's morality and sexuality, particularly public displays of 'obscenity', 'nudity' and 'indecent exposure', whether before certification, during or after admission. Several texts refer to villagers' complaints of mad women behaving 'extravagantly', 'indecently', and 'desiring connection' with men in their villages. Moral judgements are also striking on women's admission certificates such as one from 1896 concerning a 25-year old indigenous Fijian woman. She had led a 'loose and immoral life to excess lately', including 'indecent behaviour, frequently exposing herself and using indecent language in her *mekes*' (dances). She died at the asylum 2 years later. In 1898, the Native Commissioner, 'in loco parentis', signed the admission certificate for Saini, aged 22, who had insanity that was attributed to 'seduction'.

> She had the habit of smiling inanely, sprawling on floor in unseemly way on public verandah, not seeming to know "other than seemly"; sings at inopportune time . . . wanders at night in and out of people's houses without purpose when she ought by the customs of native propriety be at home with parents; easily excited and angered; came over to Suva without leave and fell into the hands of the Police as being insane.

We learn little from this about her seduction, but as in many texts, the focus is on the mad subject's embodied madness, uncontrollable, unpredictable movements and violation of cultural spaces. The text also highlights the legal restrictions on mobility faced by indigenous Fijians, particularly women, as in many other colonies. When admitting a single Indian female labourer, to the asylum in 1884, the magistrate recounted:

> She had a wild manner and expression generally, and often refused to wear any clothes during my visit. The chief conversation is of sexual intercourse and the male sex. Her gestures are often of an indecent and lascivious character.

Surviving records of the Medical Superintendent's visits to St Giles also highlighted a lurid preoccupation with the details of women's sexuality, especially that of mad European women. This may have reflected the positioning of racialised and gendered sexualities; the greater leeway assumed for Native sexuality compared to that of European women. A typical entry concerned a 55-year old European woman:

> . . . obscene delusions – her language being incessantly filthy and unrestrained and always on the subject of sex and sexuality . . . said Governor asked to have her killed, that last night several lights turned on her, fired at with electricity by several people whom she had previously seen cutting out a girl's womb.

Mad women threatened bourgeois identity with their flagrant violation of sexuality and other norms, such as work. Stoler argues that the delineation of European female sexuality was pivotal to colonial order:

> Within the lexicon of bourgeois civility, self-control, self-discipline, and self-determination were defining features of bourgeois selves in the colonies. These features, affirmed in the ideal family milieu, were often transgressed by sexual, moral, and racial contaminations in those same European colonial homes.[44]

However, respectability, domesticity and normality were also inculcated by other ethnicities in Fiji. Christian discourse was significant but women's virtue and controlled sexuality was also central to Hindu and Muslim discourses and Indo-Fijian identities.[45]

## The female body, reproduction and madness

The medicalisation of sexuality was pivotal to defining the normal and pathological not only from observed embodied sexuality but also through the medical discourse of mad bodies. The prominence of sexual and moral discourse in the madness texts reinforces how madness and bodies were gendered during St Giles' colonial era. Testimonies relating to women's admissions to the asylum linked this with their reproductive bodies, specifically menstruation, pregnancy, childbirth, miscarriage and menopause.[46] Women's reproductive functions could be deemed pathological,[47] especially when associated with diseased minds.

In contrast to the rather vague and uncertain concepts of insanity in general which Victorian psychiatry produced, theories of female insanity were specifically and confidently linked to the biological crises of the female life-cycle '... during which the mind would be weakened and the symptoms of insanity might emerge'.[48] Likewise doctors linked women's hormonal changes with female insanity in Fiji. For example, menstruation was linked to the suicide of a female *Girmitiya* in 1909 at Lautoka Hospital:

> A few days prior to her death when in hospital her menstrual period came on, and this the Hospital Superintendent informed me often causes a depressed state of mind which might account in her case for her action in taking her own life.[49]

Doctors at St Giles observed women's mental susceptibility to their 'periodicity',[50] by tracking their menstrual cycles: '23 Sept S (Indian female) very melancholic (menstruating); 20 Oct S very violent (menstruating).'[51]

Joan Busfield reiterated that there is little evidence of direct links between reproductive biology and specific mental states.[52] But Victorian and colonial doctors frequently diagnosed 'puerperal insanity' or 'mania of pregnancy' when mania or melancholia was associated with childbirth.[53] Puerperal insanity was an ambiguous diagnosis, while the duration of the puerperal period was equally vague. Although this period

conventionally lasted for 6 weeks after childbirth, puerperal insanity could be linked to pregnancy, miscarriage or lactation. Doctors sometimes applied this 'convenient label'[54] to mental disorders several years after the birth. Madness, that was linked with female reproduction, offered one 'truth' that could be identified and possibly treated.

Instead we find tragedies of post-partum depression and psychosis among the St Giles records. Between 1884–1936, approximately 25 admissions or 21 women were classified as suffering from psychiatric conditions attributed to puerperal insanity. This constituted around 10 per cent of female patients, similar to comparisons from other asylums during this period.[55] Outside Suva's asylum many women were treated for post-partum complications, including depression,[56] with traditional healing within their homes and communities. The wealthy, particularly Europeans, could hire private nursing or arrange to have mentally disturbed family treated outside Fiji. Nevertheless, among the small number of women admitted with puerperal insanity to St Giles, between 1884–1936, there were no obvious class or ethnic biases. Women's economic circumstances ranged between being destitute, villagers, *Girmitiyas,* to being married to professional men and Fijian chiefs.

One of the asylum's first patients, Annie, a European waitress, was admitted by her husband in 1884 as a private patient after suffering from 'puerperal insanity'. Aged only 21, the medical superintendent reported that she had undergone two attacks of chorea and had a generally hard life. According to the district medical officer, '…she should be certified on the basis of [being] hurried and agitated, great irritability, obscenity of language and husband said she was outrageous and had strong dislike of him'. Reports described her as suicidal, paranoid that violence was being inflicted upon her, and threatening violence towards her husband. Mrs J, previously referred to, was admitted to the asylum in 1896 diagnosed with 'puerperal melancholia, with homicidal impulses'. Her husband testified that she,

> …has long been melancholic and apathetic but during last few days has changed to restless state and in last 24 hours threatened to cut off hands of one of her children, got large knife and threatened child, recovered from her with difficulty; got out of bed and escaped from the house in the night screaming.

The medical officer also vividly recorded the embodied evidence of her madness:

> ...wild, neglected and frightened appearance; talks incoherently of persons and things; says [Doctor] is Jack the Ripper ... hallucinations of sight and hearing, hears voices and sees butterflies flying around her; illusions of sight and hearing; calls people she knows by other names (not incoherently); in mid conversation jumped up, is continually moving foolishly, no reasonable purpose.[57]

Mrs J died in the asylum in 1909, as did around 64 per cent of the women confined there, diagnosed with puerperal insanity between 1884–1966. These included Veniana, a 22-year old indigenous Fijian, admitted 2 months after childbirth in 1898. According to her husband she 'wanders; discards clothes; melancholy; refused to talk to anyone; complained devils after her; since birth refused to suckle child; won't have child near her and lost all interest in her; recently filthy habits in house'. A Native Medical Practitioner declared her insane; observations upon admission included, 'melancholy, fixed fawnlike gaze, no particular purpose to it; stoops and bends incessantly and evinces tendency to remain in any position to which guided; won't speak ... exhausted and drowsy'. Veniana died 49 days later following emergency gynaecological treatment at the Colonial Hospital. Although 'unsettled' mothers of all ethnicities and religions might be diagnosed with puerperal insanity, the reality was that poorer women were more likely to remain and die in the asylum, which could have profound consequences for their families. For example, when a destitute Muslim mother aged 31 was admitted to St Giles in 1914, what happened to her four children while she was there and after she died in 1919? A Hindu mother of two children became a patient at St Giles in 1920 and gave birth to a baby there. She remained in the hospital until she died there in 1939 while the Roman Catholic Mission on another island in Fiji cared for her children. In 1929 an elderly Fijian man took care of his 32-year old sister's baby. She had no husband and died in St Giles in 1931.

## Controlling the body to settle the mind

Fiji's lunatic asylum was erected during a period of increasing disillusionment with moral management of the mentally ill in Britain.[58] It was designed to sequester those certified insane within a controlled environment, but also incorporated principles of moral and humane care. In the early years there was little expectation of cure but some reference to appropriate moral therapy and relief from insanity. During subsequent

decades, there was more optimism that some patients could be restored to 'normality'. This hope heightened with the advent of physical interventions (such as shock treatments introduced during the 1940s) and when the 'pharmacological revolution' brought 'curative drugs' such as chlorpromazine (Largactil) to Fiji in the mid-1950s.[59]

Mad people's bodies were the focus, regardless of whether the expectation was sequestration, control, care, cure or punishment. Control and treatment of the mind was manifested through control and care of the body. Consequently the body was often a contested site between patients and caregivers and as has been emphasised, the control of gendered bodies was integral to treating insanity. Patients' bodily functions, orifices, ingestions and emissions were closely scrutinised. Conflict often broke out over bathing, eating, defecating, with forced use of laxatives, enemas and 'slats' to open the bowels, special diets, nasal and tube feeding. Early records suggest that women were possibly more prone than men to be subjected to prolonged baths and radical haircuts to remove head lice. Normality and femininity were re-constituted with personal care of hair, body and dress.[60]

After Mrs J destroyed her dress, the Chief Medical Officer asked for reports on the 'progress' of a new dress and her acquiescence to wearing it. She was reported as 'improving' after wearing this dress. Her comportment was also observed: 'she is now in a fairly quiet and playful mood, her features relaxed, lost a good deal of that hard, set, look.'[61] Mrs J's behaviour towards her husband was also scrutinised: 'If Mr J asks to see his wife allow him in your presence for 15 minutes; watch effect on her.'[62] A positive sign of normality during this visit was that Mrs J asked after her children.

However, the bulk of Mrs J's records relate to her bodily functions: notably menstruation and defecation. We know very little about Mrs J's mind from records, which mostly cited observations not introspections.[63]

> The patient remained in a fairly manageable state throughout the day, ate food fairly well, but towards 11pm she suddenly became extremely violent, tearing at the external orifice of her vagina, and otherwise behaving in a most extravagant manner, she was immediately restrained and the Mufflers, and knee and ankle straps applied, even with these all on, it was with some considerable difficulty, that the patient was kept from injuring her head and in between one of her paroxysms, I succeeded in getting her to take a dose of the

> 'Mixture' and in about ten minutes, afterwards, she went off into a sound sleep, woke up again at a little after one o'clock, was noisy, and attempted to struggle about for a little while, and then gradually fell asleep again .... The patient is now quiet and sullen.[64]

This text also indicates the struggle to control Mrs J's body through physical and spatial restraints, including drugs. Like several patients, she resisted swallowing her medication.

Women were more likely than men to be subjected to invasive treatments to settle their minds. After the Chief Medical Officer pronounced Mrs J had '...so far recovered as to be rational and harmless', he advocated a '...special gynaecological examination...as a knowledge of the sexual apparatus is essential to a proper radical treatment'. He 'found a condition which could be advantageously healed at the Colonial Hospital with a fair hope of success and of permanent cure of her mental irritability.' No further records have survived about the outcome of this procedure, which possibly may have been a hysterectomy. Mrs J's plight highlights how surgery was equated with settling or possibly curing mental illness, especially puerperal insanity. Decades later in 1947, Mrs DV, an Indo Fijian woman was admitted to the asylum suffering from 'hysteria', only 16 days before giving birth there. She was discharged 4 months later conditional on her husband re-admitting her for a tubal ligation. Instead her mental condition worsened and she was readmitted to St Giles. Mrs DV was also one of the first subjects to be treated with Cardiozol (Metrazol) and electro convulsive therapies (ECT). Over several years these produced wide-ranging reactions to her body and mind. During the following decades she was subjected to a wide range of bodily and psychotropic interventions and psychiatric diagnoses. Attempts to settle her mind and body were indicative of the transfer of new psychiatric technologies and psychotropic drugs to colonies.[65] Ostensibly there was a humane aim to calm and possibly cure, unsettled minds but hospital records and oral histories at St Giles indicated that control was frequently a consideration. Fiji was also a site of haphazard psychiatric experimentation with these new therapies. Bodies, primarily women's, were experimented on with 'deep sleep' or Pentothal (Thiopentone) narcosis (1947), insulin injections to induce sweating (1955), and 'acid' treatment (1954).[66]

Settlement of disordered minds also extended to activities for mad bodies. During Victorian times this was known as the 'work cure';

later designated occupational therapy or ways to 'activate' the patient. Such therapies reflected the multiple subject locations of mad people and were organised along not only gendered but also racial and class lines. Initially, Native men and some women produced crops but later flower cultivation was specifically a female task that could include Europeans. In 1938 the hospital declared: 'All the mattresses in the female ward have been remade and a complete set of dresses of a new design for the female patients have been made by the patients themselves in 1938. A number of Samoan baskets and fans were also woven.'[67]

Native female and male patients undertook cleaning for patients and staff. Occasionally some men, including Europeans, tackled more 'skilled' work (such as building and tailoring). Although European women participated in appropriate feminine activities such as needlework, reading or playing cards, they were expected to do some domestic work.[68] Work indicated the restoration of femininity, as recorded in Mrs J's records,

> she however, seems to be bright and cheerful, was employed in sweeping her room out . . . Actively employed yesterday (by her own request) in assisting the female attendant, in hanging out the Asylum washing, etc. Mrs J still doing well, went for a walk in the Gardens on Saturday, and again yesterday; reads a good deal now.[69]

## Conclusion

Interventions in health and illness, including madness, were part of the colonial settlement of Fiji. After some Fijian chiefs entrusted Queen Victoria with the protection of indigenous Fijians, formal colonial intervention accelerated to secure a settled and economically viable colony. In Fiji a dual system of sustaining indigenous communities through indirect rule and indigenous hierarchies co-existed with extensive plantation development that relied upon immigrant indentured labour from India until 1920. The state continued to sustain separate administrative spheres for indigenous Fijians and Indo Fijians. Meanwhile a small but significant European community settled in Fiji. The maintenance of ethnic boundaries was pivotal to colonial settlement. These were cast in the discourse of race but as this chapter has emphasised, gendered boundaries were equally part of colonial order. The settling of colonial bodies was through colonial discursive and formal intervention

in biological and social reproduction and other forms of productive labour.[70] Sexual control was central to categorising coloniser and colonised.[71]

Were mad people, moreover mad women, with both unsettled minds and hormones, an impediment to colonial order? Probably not, because there was limited visibility of the insane and their numbers were few in Fiji. But women's challenge to normality presented ambiguities because, as described, some women certified as insane became dis-engaged from conventional norms of rationality only after they became imperfect mothers.

While the state instituted legislative structures to frame colonial minds, how did this articulate with local and migrant cultures in Fiji? If, as Foucault insisted, the micro-site of power resides in the family, how did Fiji's cultures reproduce the framing of normal minds? The majority of ethnic Fijians admitted to St Giles were from villages. Why did families decide to commit mad kin when they had long cared for and controlled them? Under colonialism there was a shifting ambivalence towards western medicine. Hospitals were known as places of death (*vale ni mate*), but Fijians also embraced western biomedicine. Pivotal to this were the co-option of Fijians as doctors and nurses[72] and the extension of western health care into rural areas. The state also bolstered the authority of Fijian officials, who frequently had a key role in providing testimony concerning a villager's insanity. Boundaries of acceptable behaviour shifted, as modern concepts of mental abnormality became entwined in local constructions. British notions of orderly society became articulated with indigenous worlds.[73]

Although the colonial management and framing of madness was markedly gendered in Fiji, ethnicity was significant. Women had lower asylum admission and death rates than men but overall Indo-Fijians had high admission and death rates. Proportionately higher death rates were found among Fijian indigenous male patients. Destitution and class thread through this. St Giles was managed according to social considerations, that is gender and other colonial hierarchies, more than any rationale based upon patients' mental conditions. As Sally Swartz emphasised in Cape Colony, the classification process supposedly rendered any difference as irrelevant, as a homogenous insane population was produced, but difference was reproduced within the asylum.[74] A recovered patient conformed to the colonial norms of difference with respect to gender, comportment, ethnicity, status and class outside the asylum.

Colonial 'madness' infrastructure reflected and framed primarily gender, then ethnic, and lesser so, class and other hierarchies. Not only mad bodies, but also staff were allocated spaces within these. The embodiment of gender and madness was discursively produced through texts such as admission certificates and medical journals. Evidence of 'madness' was accrued from reports of mad bodies looking, smelling, sounding and acting differently (especially violently or out of control) to 'normal' bodies; a normality discursively framed by lay, legal and medical communities along gendered, racial and class lines. Women's madness was especially articulated with respect to gender roles, sexuality, and linked women's insanity with both their domestic lives and their bodies. This was notably evident in the discussion of puerperal insanity. But the transgressions of feminine norms were:

> ...not in themselves sufficient to guarantee committal to a mental hospital. These behaviours had to develop in a particular material and social context to warrant certification and committal. Others had to decide that such behaviours could no longer be contained or tolerated.[75]

Efforts to settle disordered minds in colonial Fiji began in 1884 and ran parallel to the gradual inculcation of more passive and everyday forms of colonial settlement, including presumptions of embodied mental normality. Madness at one level was framed as a homogenous other but this could pertain to unsettled bodies and minds of both colonisers and colonised. Within this, demarcations of madness was defined, incarcerated, controlled and occasionally treated, according to colonial stereotypes of gender and ethnicity. Such stereotypes were not just a foreign import but became integral to the cultural norms and traditions within Fiji's different communities. New discourses of madness became localised, even if the colonial administration had erected infrastructure that appeared to settle disordered minds.

## Notes

1. Part of this chapter was originally published as J. Leckie, 'The Embodiment of Gender and Madness in Colonial Fiji', *Fijian Studies,* 3, 2 (2005) 312–37. I am grateful for the assistance of staff at St Giles Hospital, Suva and Fiji National Archives and to the University of Otago for providing research funding, which enabled assistance from Karin Reid.
2. E. Li Puma, *Encompassing Others: The Magic of Modernity in Melanesia* (Ann Arbor: 2000), p. 24.

3. This name was not adopted until 1960 but this chapter uses the term St Giles to refer to former names of the same institution; Fiji's Public Lunatic Asylum, and Fiji's Mental Hospital.
4. See, for example, K. Ram and M. Jolly (eds), *Maternities and Modernities. Colonial and Postcolonial Experiences in Asia and the Pacific* (Cambridge: 1998); A. Stoler, 'Carnal Knowledge and Imperial Power: Gender, Race, and Morality in Colonial Asia', in M. di Leonardi (ed.), *Gender at the Crossroads of Knowledge: Feminist Anthropology in the Postmodern Era* (Berkeley: 1991), pp. 51–101.
5. See, for example, E. Grosz, *Volatile Bodies: Towards a Corporeal Feminism* (St Leonards: 1994); J. Price and M. Shildrick (eds), *Feminist Theory and the Body: A Reader* (Edinburgh: 1999).
6. A. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham: 1995).
7. See J. Leckie 'Modernity and the Management of Madness in Colonial Fiji', *Paideuma. Mitteilungen zur Kulturkund* 50 (2004) 551–74.
8. M. Foucault, *Madness and Civilization. A History of Insanity in the Age of Reason.* trans. R. Howard (London: 1967) [Originally published 1961]. The critique of Foucault's 'great confinement' was applied to colonial Africa by Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: 1991), p. 101 and Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: 1995), p. 44. Subsequent assessments of psychiatry in varying contexts have dismissed the 'great confinement' thesis. See, R. Porter and R. Wright (eds), *The Confinement of the Insane. International Perspectives, 1800–1965* (Cambridge: 2003).
9. M. Jolly, 'Other Mothers: Maternal "Insouciance" and the Depopulation Debate in Fiji and Vanuatu, 1890–1930', in K. Ram and M. Jolly (eds), *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific* (Cambridge: 1998), pp. 177–212; N. Thomas, 'Sanitation and Seeing: The Creation of State Power in Early Colonial Fiji', *Comparative Studies in Society and History,* 32 (1990) 149–70.
10. Colonial Secretariat's Office (CSO) 83/29, Seed (Police Superintendent), 1881 annual report; CSO 83/29, Despatch 185, 30 December 1881.
11. CSO 83/27, 1881 address to the Legislative Council, 28 December 1881.
12. J. Comaroff and J. Comaroff, *Ethnography and the Historical Imagination* (Boulder: 1992); D. Denoon, *Public Health in Papua New Guinea: Medical Possibility and Social Constraint, 1884–1984* (Cambridge: 1989); R. MacLeod and M. Lewis (eds), *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: 1988).
13. M. Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies*, 9, 2 (1983) 220.
14. CSO 84/1340, 1 July 1884, Halkett to Colonial Secretary.
15. CSO 83/34, Despatch 122, 20 October 1883.
16. R.B. Joyce, *Sir William MacGregor* (Melbourne: 1971), p. 25.
17. B.V. Lal, *Crossing the Kala Pani: A Documentary History of Indian Indenture in Fiji* (Division of Pacific and Asian History, ANU, Canberra and Fiji Museum, Suva: Prashant Pacific Book, 1998).
18. C. Knapman, *White Women in Fiji 1835–1930: The Ruin of Empire* (Sydney: 1986) documents European women, colonialism and sexuality in Fiji.

19. W. Brunton, ' "A Choice of Difficulties": National Mental Health Policy in New Zealand, 1840–1947' (Unpublished Ph.D. Thesis, University of Otago, Dunedin, New Zealand: 2001); M. Lewis, *Managing Madness: Psychiatry and Society in Australia 1788–1980* (Canberra: 1988).
20. T. Ballantyne, 'Race and the Webs of Empire: Aryanism from India to the Pacific', *Journal of Colonialism and Colonial History*, 2, 3 (2001); C. Coleborne, 'Making "Mad" Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum', in D. Kirkby and C. Coleborne (eds), *Law, History, Colonialism: The Reach of Empire* (Manchester: 2001), p. 108.
21. W. Ernst, 'Colonial Policies, Racial Politics and the Development of Psychiatric Institutions in Early Nineteenth-Century British India', in W. Ernst and B. Harris (eds), *Race, Science and Medicine, 1700–1960* (London: 1999), pp. 82–7.
22. D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913–1997* (London: 1998), p. 5.
23. CSO 2961/1892, Meeting, Board of Visitors, 27 September 1892.
24. CSO 2961/1892, Chief Medical Officer to Colonial Secretary, 6 September 1892.
25. CSO 8621/1914.
26. CSO 8621/1914, Meeting of Board of Visitors, 28 September 1914; Paper of the Fiji Legislative Council, CP 4/1887. Daily rates for first class patients were 10/- for the first 3 months, then 6/- 8d, and for second class patients, 2/- for first 3 months then 1/- 6d.
27. M. Jolly, 'Other Mothers: Maternal "Insouciance" and the Depopulation Debate in Fiji and Vanuatu, 1890–1930', in K. Ram and M. Jolly (eds), *Maternities and Modernities. Colonial and Postcolonial Experiences in Asia and the Pacific* (Cambridge: 1998), pp. 177–212; A. McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest* (New York: 1995), p. 48; N. Thomas, 'Sanitation and Seeing: The Creation of State Power in Early Colonial Fiji', *Comparative Studies in Society and History*, 32 (1990) 149–70.
28. J. Mills, *Madness, Cannabis and Colonialism: The Native Only Lunatic Asylums of British India 1857–1900* (Basingstoke: 2000), p. 42.
29. J. Busfield, *Men, Women and Madness* (London: 1996); P. Chesler, *Women and Madness* (Garden City, NY: 1972); E. Showalter, *The Female Malady. Women, Madness, and English Culture, 1830–1980* (New York: 1985).
30. B. Brookes, 'Women and Mental Health: An Historical Introduction', in S.E. Romans (ed.), *Folding Back the Shadows: A Perspective on Women's Mental Health* (Dunedin: 1998), pp. 15–22; S. Swartz, 'Lost Lives: Gender, History and Mental Illness in the Cape, 1891–1910', *Feminism and Psychology*, 9, 2 (1999) 152–58; N. Tomes, 'Historical Perspectives on Women and Mental Illness', in R.D. Apple (ed.), *Women, Health, and Medicine in America* (London: 1990), p. 145.
31. Pseudonyms are used here. Unless referenced, primary citations in this paper are from doctors' and patients' records located at St Giles Hospital, Suva. To protect patient confidentiality, specific references are not given.
32. A.E. Becker, *Body, Self, and Society: The View from Fiji* (Philadelphia: 1995).
33. N. Tomes, 'Historical Perspectives on Women and Mental Illness', in R.D. Apple (ed.), *Women, Health, and Medicine in America* (London: 1990), p. 145.

34. B.V. Lal, 'Veil of Dishonour: Sexual Jealousy and Suicide on Fiji Plantations', *Journal of Pacific History,* 20, 3 (1985) 135–55.
35. W. Ernst, 'European Madness and Gender in Nineteenth-century British India', *Social History of Medicine* 9, 3 (1996) 362; Y. Ripa, *Women and Madness. The Incarceration of Women in Nineteenth-Century France,* Translated by C. du Peloux Menage (Oxford: 1990), p. 62.
36. Noted by J. Mills, *Madness, Cannabis and Colonialism* (Basingstoke: 2000), p. 146; J. Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: 1999), p. 50; S. Swartz, 'Colonizing the Insane: Causes of Insanity in the Cape, 1891–1920', *History of the Human Sciences,* 8, 4 (1995) 39–57.
37. R. Porter, A *Social History of Madness: Stories of the Insane* (London: 1987), p. 231.
38. N. Tomes, 'Historical Perspectives on Women and Mental Illness', in R.D. Apple (ed.), *Women, Health, and Medicine in America* (London: 1990), p. 163.
39. Testimony, District Commissioner, Taveuni and Husband's Employer.
40. For example, T. Sanadhya, *My Twenty-One Years in the Fiji Islands and The Story of the Haunted Line,* Translated by J.D. Kelly and U.K. Singh (eds) (Suva: Fiji Museum: 1991).
41. A study of an asylum in New Zealand, found that delusions of wealth and influence corresponded to the ideal image of the powerful male. J. Holloway, ' "Unfortunate Folk". A study of the Social Context of Committal to Seacliff 1928–1937', in B. Brookes and J. Thomson (eds), *'Unfortunate Folk', Essays on Mental Health Treatment 1863–1992* (Dunedin: 2001), p. 166. This was not so clearly delineated in the Fijian context.
42. A. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham: 1995); A. McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest* (New York: 1995), pp. 51–101; See also F. Cooper and A. Stoler, *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley: 1997).
43. J. Comaroff and J. Comaroff, *Of Revelation and Revolution: Christianity, Colonialism, and Consciousness in South Africa* (Chicago: 1991).
44. A. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham: 1995), p. 8.
45. J. Kelly, *A Politics of Virtue: Hinduism, Sexuality, and Countercolonial Discourse in Fiji* (Chicago: 1991).
46. J. Busfield, *Men, Women and Madness* (London: 1996), pp. 143–65; E. Showalter, *The Female Malady. Women, Madness, and English Culture, 1830–1980* (New York: 1985), pp. 55–9.
47. D. Russell, *Women, Madness and Medicine* (Cambridge: 1995), p. 13.
48. E. Showalter, *The Female Malady. Women, Madness, and English Culture, 1830–1980* (New York: 1985), p. 55.
49. CSO 1571/1909, 1 February 1909, Regional Inspector of Immigrants Lautoka to Agent-General of Immigration.
50. Ibid.
51. Case Book, St Giles, 1914.
52. J. Busfield, *Men, Women and Madness* (London: 1996), p. 165.

53. According to H. Marland, ' "Destined to a Perfect Recovery": The Confinement of Puerperal Insanity in the Nineteenth Century', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London: 1999), p. 144, 'it is likely that some cases of puerperal mania were in fact women suffering from puerperal fever and in a state of delirium'.
54. Ibid.
55. Ibid. p. 143.
56. A.E. Becker, 'Post-partum Illness in Fiji: A Sociosomatic Perspective', *Psychosomatic Medicine,* 60 (1998) 431–38.
57. Doctor's Notes, 1896.
58. J. Busfield, *Managing Madness: Changing Ideas and Practice* (London: 1986), pp. 256–7.
59. J. Leckie, 'Discourses and Technologies of Mental Health in Post-War Fiji', in B. Lal (ed.), *The Defining Years, Pacific Islands, 1945–65* (Canberra: 2005), pp. 151–73.
60. C. Coleborne, ' "She Does Her Hair Up Fantastically": The Production of Femininity in Patient Case Books of the Lunatic Asylum in 1860s Victoria', in J. Long, J. Gothard, and H. Brash (eds), *Forging Identities: Bodies, Gender and Feminist History* (Nedlands: 1997), pp. 47–68.
61. July 1896, Chief Warder to Chief Medical Officer.
62. 10 August 1896, Chief Medical Officer to Chief Warder.
63. cf. J. Mills, *Madness, Cannabis and Colonialism* (Basingstoke: 2000), p. 70.
64. Reports, 1896, Chief Warder to Chief Medical Officer.
65. See J. Leckie, 'Discourses and Technologies of Mental Health in Post-War Fiji', in B. Lal (ed.), *The Defining Years, Pacific Islands, 1945–65* (Canberra: 2005), pp. 151–73.
66. It is uncertain what this was. Psychiatric treatments during the 1940s administered nicotinic acid and glutanic acid, along with vitamin therapy to treat confusion and delirium, especially with senile psychoses.
67. F48/4/5, Annual Report, Mental Hospital.
68. Information from Annual Returns, Lunatic Asylum, *Blue Book of Fiji* (1884–1940) and oral testimony.
69. Reports, August 1896 Chief Warder to Chief Medical Officer.
70. For example, M. Jolly, 'Other Mothers: Maternal "Insouciance" and the Depopulation Debate in Fiji and Vanuatu, 1890–1930', in K. Ram and M. Jolly (eds), *Maternities and Modernities. Colonial and Postcolonial Experiences in Asia and the Pacific* (Cambridge: 1998), pp. 177–212; V. Luker, 'A Tale Of Two Mothers: Colonial Constructions Of Indian And Fijian Maternity', *Fijian Studies: A Journal of Contemporary Fiji*, 3, 2 (2005) 357–74.
71. A. Stoler, 'Carnal Knowledge and Imperial Power: Gender, Race, and Morality in Colonial Asia', in M. di Leonardi (ed.), *Gender at the Crossroads of Knowledge: Feminist Anthropology in the Postmodern Era* (Berkeley: 1991), p. 52; A. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham: 1995).
72. J. Leckie, 'Nursing and Modernity: Negotiating Traditions and Cultures in Fiji', in V. Luker and M. Jolly (eds), *Engendering Health in the Pacific: Colonial and Contemporary Perspectives* (Leckie, forthcoming).

73. M. Kaplan, *Neither Cargo Nor Cult: Ritual Politics and the Colonial Imagination in Fiji* (Durham: 1995), p. 360.
74. S. Swartz, 'Colonizing the Insane: Causes of Insanity in the Cape, 1891–1920', *History of the Human Sciences,* 8, 4 (1995) 401.
75. S. Garton, *Medicine and Madness: A Social History of Insanity in New South Wales, 1880–1940* (Kensington, NSW: 1988), p. 140.

# 6

# The 'Godless' Freud and his Indian Friends: An Indian Agenda for Psychoanalysis[1]

*Shruti Kapila*

In her article, 'Freud in the Tropics', Jacqueline Rose writes of the 'missed encounter' of Australia and its place and significance for the destabilization of the Freud–Jung partnership. The 'phantom' of Australia for both Freud and Jung becomes an entrée for Rose to chart and question how it produced differences between them. She asks, 'What can this ... encounter ... tell psychoanalysis, and the forms of Western thinking which it both embodies and queries, about itself?'[2]

The aim of this chapter is similarly to interrogate what happens to psychoanalysis when it travels outside its Western confines. If Australia for Rose highlighted the self-identity of western thinking, then what does the now forgotten encounter between Freud, Jung and India tell us about classical psychoanalysis and, further, what does its appropriation by their Indian counterparts tell us about late colonial India? Recent discussions of the Indian context have seen psychoanalysis as inherently Western. Indeed some have seen Freud as a 'typical representative of Western thought that had viewed the Indian as inferior'.[3] This may have been true, but is less interesting than the way in which the Indian psychoanalytic movement engaged early, directly and critically with Freud. Psychoanalysis became a fertile site for potential explanations of the modern condition. What was it that was compelling within the Freudian oeuvre that animated so much reflection by Freud's Indian counterparts and colleagues? Why and how was psychoanalysis generative of a contemplation of the nature of the modern condition which further resulted in both a scholarly and a public discussion?

The objective here is thus to bring classical psychoanalytical and Indian writings on Freud within a single field of interpretation, focussing specifically on the question of religion. On the one hand, religion was at the centre of the most critical debates between Freud and Jung and,

on the other, it had long been seen as the defining difference between India and the West. Precisely by intervening in the domains of Freud's ideas of the irrationality of religion and Jung's perceptions of India as a spiritual realm, psychoanalysis in late colonial India was deployed in order to mount a rational interpretation of religion.

Through a schematic approach, this article will analyse three key themes in the making of an Indian psychoanalytic enterprise. In the first instance, the institutional and social context that facilitated the articulation of Indian psychologists will be outlined.[4] The second section will then map the intellectual trajectory of the Indian psychoanalytic movement by exploring the interplay between religion and psychoanalysis. Finally, the focus will switch to the more diffused and public deployment of Freud (as opposed to scholarly or professional), in Jawaharlal Nehru's *Autobiography*.[5] This will again address the issue of religion in relation to the making of a modern self, while locating a Freudian framework in Nehru's writing.

## Associations and sociality: the Indian psychoanalytic movement

As early as 1869, Mahendra Lal Sircar, the founding figure of what has been termed 'national science', singled out the potential within psychology to counteract the 'super-ordination' of objective modalities in scientific practices. In a lecture at the Canning Institute in Howrah, in the heyday of positivist science, Sircar called for the integration of objective methods with subjective approaches in relation to the study and problems of the human mind.[6] Critical of most contemporary psychiatric approaches to the nature of human mentality and the evolutionary scaling of different mentalities, Sircar struck a strikingly prescient Freudian note. He argued:

> There are states of mind which are perfectly unconscious and therefore cannot come within the domain of consciousness. Hence it is that some of the most difficult problems of psychology have hitherto met with no satisfactory solution ... [T]he simple and single operation of each faculty is very often hidden and incapable of being known, except by a most rigorous subjective analysis.[7]

As discussed elsewhere, Sircar was keen to mount an alternative frame of reference to the prevalent positivist tradition with the purpose of straddling religion with science; evolution with morality.[8] While Sircar's interests were predominantly in the field of homeopathy, the potential

that he identified within psychology to explore the 'hidden' and the negotiation of the religious with the scientific became an instructive antecedent.[9]

Three decades after Sircar first professed the significance of psychology in India and the same year that Freud launched the International Psychoanalytic Association, the first institutional foray into psychology in India was made, albeit not in a psychoanalytic tenor. In 1905, Brojendra Nath Seal, George V Professor of Mental and Moral Philosophy wrote the first independent course in Experimental Psychology at Calcutta University.[10] Early students of this course included N.N. Sengupta who was instrumental not only in promoting Wundtian experimental psychology in India but also, more significantly for our concerns here, Girindrashekhar Bose, often referred to as the 'Indian Freud'. When Bose qualified both in medicine and in psychology, he was appointed as a lecturer in clinical psychology at Calcutta University and, in 1917, Bose offered the first course in Abnormal Psychology in India.[11] In the early 1920s, Dhaka and Mysore universities also established separate departments for psychology and Bombay, Lahore, Allahabad and Benaras also became sites of similar endeavours.[12] Indeed, by the mid-1920s psychology acquired a comfortable position not only within the Indian university system but also had its own professional body, the Indian Psychological Association, that regularly published its own quarterly journal, *The Indian Journal of Psychology*.[13]

It has been argued that the period between 1890 and 1910 witnessed an unparalleled Indian interest in science that 'belied any narrow definition of colonial science'.[14] This unprecedented interest has also been explained in terms of a 'nationalist' response and as a critique of colonialism.[15] In the context of an enthusiastic Indian engagement in other sciences, psychology in the national context was something of a latecomer. However, to situate it within the broader history of psychoanalysis, the Indian initiative in the first few decades of the twentieth century was contemporaneous with its international counterpart, and on occasion altogether pioneering. However, psychology in India owed much to Calcutta, the 'undisputed centre of national science'.[16] This was not only because influential analysts like Bose lived there but also because importantly there was a pre-existing associational culture of science that was interrogative rather than utilitarian in the nature of its scientific ventures.[17]

When the first annual Congress of the Association was held at the University Hall of Bombay University in January 1926, self-congratulation and rejoicing marked the presidential address at the success of the many 'efforts' and the growing interest in psychology.[18]

Importantly, the initiative was almost entirely an Indian affair. Apart from Owen Berkeley-Hill, the superintendent of the Ranchi Mental Hospital – who had been analysed by Freud's biographer Ernest Jones – all of the executive and other committees and most other members were Indian. By the late 1920s, the Association had become the 'official' body of the discipline of psychology, lobbying, organizing seminars, creating institutions and disseminating its agenda. It was in the main immune from colonial psychiatric concerns apart from the occasional critical encounter. When Berkeley-Hill presided over the deliberations of the Psychology section of the Indian Science Congress in 1927 the doubly exceptional nature of the event did not elude him. In his address he confessed;

> With no mixed emotions . . . I regard your choice of a psychiatrist as evidence of the catholicity of the interests of . . . . the Congress for hitherto the post has been filled by an academic psychologist. I am further sensible to the fact that I am the first European to preside over the deliberations of this section.[19]

Frenetic activity on the one hand interconnected various institutions and on the other brought together individual pursuit within a single milieu. Significantly, there was the formation of a public for the new discipline and its agents. In a minimalist sense, this public consisted of the readership and correspondents of the journal, and the delegates and audience of the well-attended annual conferences and congresses. Undoubtedly, this was part of the overly visible educated elite that more often than not usurped leadership in the political or intellectual arenas in late colonial India. Their endeavours were perhaps obscured within the international arena.

However, away from the bustling Association, the coming together of a cluster of men at Bose's house in Calcutta did attract international attention. Three years prior to the founding of the Psychology Association and soon after the publication of his D.Sc. thesis written at Calcutta University – 'The Concept of Repression' – in 1922, Bose set up the Indian Psychoanalytic Society at his own home.[20] In March 1922, in a letter to Lou Andreas-Salome, a long-term correspondent and a common friend and critic of Freud, Nietzche and Rilke, Freud wrote:

> The most interesting item of news in the psycho-analytic world is the foundation of the local group in Calcutta, led by Dr. G. Bose, a Professor Extraordinary and author of the book, *The Concept of*

> *Repression*. With one exception the members are all learned Hindus. From the same quarter I received an 'Imaginative Portrait', that is a painting by someone who is said to be a famous Indian artist, and which represents his idea of my person, of whom he has never seen a likeness. Naturally, he makes me look the complete Englishman.[21]

Though unmarked in subsequent histories of psychoanalysis, this 'most interesting item of news' was not the first piece of information that Freud had from Calcutta, given that Freud and Bose were correspondents for 11 years and Freud had received and read Bose's book. The curiosity and the need visually to capture Freud 'imaginatively' indicates the stimulus that Freudian ideas had for his friends in Calcutta. However, his representation as an Englishman is suggestive of the pervasivity of the English (and the colonial) in any imaginative exercise, whether it was the portrait or psychoanalysis in late colonial India.[22] The simultaneity of this relationship to Freud with an acute sense of awareness of colonialism epitomized the Indian engagement with psychoanalysis.

Twelve men came together at Bose's house in Parsibagan in Calcutta and the International Psychoanalytic Association immediately gave it associate membership even before such a membership was accorded to the French body.[23] Nandy simply interprets this international enthusiasm as Freud's desire to house and 'spread' psychoanalysis beyond Vienna.[24] A contemporary reminiscence, however, lends itself to an alternative perspective:

> There was a club at 14 Parsibagan, the Calcutta residence of the Bose brothers, an *Adda* [a place for careless talk or the chat of intimate friends] in Bengali would be a more fitting term, for it was bound by no formal rules and regulations. Among its members could be counted many great names, artists, poets, journalists, historians, litterateurs, medical men, psychologists and scientists. It was known as the Arbitrary Club, but we called it *Utkendra Samiti* in Bengali which being rendered into English would read as the Eccentric Club. Along with tea, chess, and cards, members would hold discussions on all possible subjects under the sun . . . . The atmosphere of the Club was at that time surcharged with the electric current of psychology and literature.[25]

Arbitrary or eccentric, this circle of men was not merely part of an expanding empire of psychoanalysis.[26] The aim here is not to etch out a history of the social practice of *adda* or to peculiarise it as something

inherently Bengali.[27] Rather, it is to highlight that the enchantment with psychoanalysis was not confined to its academic pursuit. Hartnack notes that the Society grew rapidly and within a decade its membership had risen to 35, with 15 members who were practising analysts and 20 associates who had not undergone training in analysis.[28] She also emphasises that psychoanalysis was 'much talked about', gaining 'influence in India' with radio broadcasts and magazine articles disseminating Freud and his Indian engagement. Psychoanalytic ideas were thus not removed from either the intimate or the social, the coming together of which Dipesh Chakrabarty has called 'sociality'.[29] The circulation of ideas in congresses, associations and international correspondences was articulated in a transactive terrain in which neither the academic/professional nor the intimate/social were hermetically sealed from one another.[30] Though this 'sociality' was bound up with the national and the international, the inter-connections between them would necessarily not have been 'equal' given the uneven distribution of institutional power between them. Nevertheless, this 'sociality' afforded an audience for psychoanalysis in late colonial India bringing together orality and communication with the written word and has some wider implications, especially in relation to other colonial sciences of the mind.[31]

Colonial psychiatry through the institution of the asylum, despite having a long, visible and functional presence in key urban centres, decidedly remained an enclave of practices.[32] Conversely, the inter-connective nature of sociality – with its intimacy of friendship and its relation to the associative culture – facilitated a unique mapping of a new discipline in which individuals were networked across the country and where conversation animated a city.[33] Both the formal structures of the Association and the Society and their less formal elements afforded a public life for the Indian psychoanalytic venture in which the circulation of ideas played a critical role.[34] This juxtaposition of a new kind of space with its parleys – whether it was the University Hall of Bombay with its serious deliberations or the Bose living room with its friendly banter – alludes to the endeavour to make psychoanalysis Indian.

Freud became the defining trope between colonial psychiatry and an Indian psychology. Bose himself articulated the dilemmas and differences between the two. In an article in 1931, he argued that:

> This [gulf between studies in the pathological and the psychological] is due to the fact that abnormal psychology owes its development not

> to scientific curiosity which is responsible for the growth of psychology but to the social urge which drives a practical physician to the study of medicine and therapeutics.[35]

In other words, while asylum-medicine and colonial governmentality were preoccupied by the 'practicalities' of ordering the social, psychology according to Bose was home to a 'scientific spirit' of interrogation in which it was difficult to separate the pathological from the mundane or the normal. This distance between the colonial–governmental realm and the Indian reflexive engagement with psychoanalysis proved to be strategic in that it spared the latter from the ever-sceptical eyes of 'scientific validity' that haunted Freud throughout his career.

There was, however, an ease with which psychology entrenched itself at least within the academy and within a high culture of national science. By the mid-1920s psychology was being taught as a separate discipline in over a hundred institutions.[36] Sengupta argued that the lack of infrastructural support, which was disproportionate to the interest that psychology had generated, ought not to deter the exploitation of the potential of the discipline for addressing contemporary concerns about the nature of human mentalities.[37] He further suggested an almost transcendental and programmatic position for psychology whereby its methods could be deployed to understand various crises in the social, economic and political realms since, according to him, 'human nature' and mind underpinned these realms and their related strife. 'Psychology', he noted significantly 'has expanded into a cultural atmosphere'.[38] He went on to single out the nature of the Indian as particularly predisposed to it and remarked, 'The aptitude for psychological causes to human events, to observe mental characters, and to endeavour for the development of mental capacities, seem ingrained in the Indian mind.'[39] A similar attitude brought Jung to India a decade after Sengupta had rehearsed a common understanding of things Indian. The vicissitudes of the inter-traversed arenas of things understood to be Indian and psychoanalysis is discussed below.

## Freud and religion: an Indian agenda for psychoanalysis

In a defining *fin de siecle* work, Freud broke down the distinction between the abnormal and the normal and between the significant and the insignificant. Further, within psychoanalytic theory a continuum replaced the break that biology had introduced with the contrast between the pathological and the physiological.[40] This enabled psychoanalysis to

seek patterns in the everyday and a frame of reference within which slips of the tongue were as significant as religious practices. Freud's oeuvre can crudely be divided into two separate preoccupations. In one, neurosis of the self was of primacy. This redefined the relationship between the patient and the doctor or, rather, replaced that relationship with that of the client and the analyst. In the second, an embattled Freud positioned his atheism in a climate of professional and political hostility to foreground a psychoanalytic interpretation of religion and the modern condition. Though it is somewhat heuristic to separate the Freudian corpus in this manner, the following discussion will mainly engage with the latter preoccupation.

The Indian engagement was premised on the promise of the Freudian potential to explain the repertoire of the normal as opposed to the deviant or the plain anxious. The salience of the distinction between European and Indian appropriations, understandings and uses of Freud lies precisely in the nature of the Indian engagement, which, in its public discussion, steered clear from the psychopathology of the everyday and on occasion chided its international counterpart for its fixation on hysteria. In his essay, *Suggestions for a New Theory of Emotions*, Suhrit Chandra Mitra reasserted the centrality of the normal in the psychoanalytic framework:

> The grouping together of Psychoanalysis with the pathology of feeling and emotion into a separate part maybe justified by the fact that the psychoanalysts have so far dealt mainly with pathological cases, but it should not go unchallenged if it betrays any willingness on the part of the Symposium [of the International Psychoanalytical Association] to recognise that Psychoanalysis has any contribution to make to normal psychology.[41]

From the outset, a critical attitude towards psychoanalytic theory informed Indian psychoanalysis, whether it was the relatively more celebrated Bose or the later almost altogether forgotten cohorts of the Indian movement. Bose's first work, *A Concept of Repression* had critiqued the later much maligned Freudian libidinal theory. Bose in a direct attack on one of the central elements of the psychoanalytic framework had suggested that it was the presence of opposing sets of wishes that generated a need for its repression rather than the persistence of infantile sexuality in the unconscious. In a critique that was as prophetic as it was unheard, Bose further argued that the key opposing set of wishes was the simultaneous presence of the desire to be female and

male.[42] While working with his mostly male clients, Bose held on to this theory and devised apposite analytical techniques – namely the 'see-saw mechanism' of free-association – over the next decade.[43] By drawing on his own clinical experience and material, Bose revised psychoanalytic theory and method but at the same time cautioned against its application only to what he called, 'isolated problems . . . e.g., the genesis of homosexuality, the origin and adjustment of oedipus wish, etc'.[44] In other words, even when devising a new clinical method, Bose hinted at the wider potential and implications of psychoanalysis. Though a member of the editorial board of the *International Journal of Psychoanalysis*, Bose published his critique in the national journal. Further, in the correspondence between them, Freud was unsympathetic to, if not dismissive of, his claims.[45] Bose however, remained steadfast and qualified the second aspect of Freud's libidinal theory – the Oedipal-complex – by drawing upon his own clinical material which in turn reflected a more diverse basis in terms of both gender and race.[46] Bose's critique of the Freudian Oedipal rendition was premised on culturally locating the Hellenic within the European and by relativizing the maternal and the paternal roles across cultures.[47] While literary critics and ethnopsychologists have subsequently mapped elements of psychoanalytic theory with Hindu myths, the emphasis here is on the theoretical confidence of Indian psychoanalysis that further premised, as we will see, their interpretations of the place of religion.[48]

By the late 1920s, Freud could no longer ignore India. The question of the place of religion in psychoanalysis, posed by his old friend Carl Jung, became increasingly inescapable. Contemporaneously the question of religion figured in discussions within Indian psychoanalysis. By focussing on the issue of religion, the aim is to address both sides of the question posed by Jacqueline Rose when she locates 'tropical' Australia in early psychoanalysis.[49] In other words, not only what Freud does to these 'other' places like India but also what does India do to classical psychoanalysis.

Religious ruminations were part of Freud's clinical and interpretative works, despite his avowed atheism.[50] In his early attempt at psychoanalyzing religion, Freud drew a homologous relationship between religious practices and neurotic patterns.[51] Twenty years later, and after the consequences of the First World War had become apparent, Freud deployed classical logic, in his explication of religion in *The Future of an Illusion* whereby religion was seen as an object for scientific investigation and which could be refuted by evidence.[52] Freud pointed out the difficulty in refuting and proving religious doctrines conclusively.

He argued that 'the increase of the scientific spirit has displayed the lack of evidence, errors and fatal resemblance . . . [to] the mental problems of primitive people and times' in religious ideas.[53] Freud thus drew a homologous and causal relationship between religion, neurosis and the primitive.[54] This triangular relationship became in the later Freudian oeuvre the entry-point to discuss the question of civilization. From the mid-nineteenth century, the term civilization in relation to human mentalities implied cultural contrast and a hierarchical positioning of different cultural forms.[55] Civilization, in Freud (and Jung's) writings not only assumes this but also has another distinct meaning. While there was acrimony and disagreement between Freud and Jung on religion and its place in relation to civilization, there was agreement on what they both meant by civilization. Civilization in the classical psychoanalytic writings implies the modern condition. It connotes, not so much the stage in history in an overtly evolutionist sense, but refers more specifically to the negative consequences of modernity. When discussing the nature of civilization, there is a simultaneous avowal and wonderment and a sense of self-congratulation at the modern West (Freud and Jung routinely used phrases like the 'white man' and 'his arrival in civilization') with a sense of pessimism, especially in Freud's later works about the state of that modern condition.[56] For Freud, religion is part of the problem and the source of pessimism. In *Civilization and its Discontents* Freud makes an impassioned and a hyper-rational critique of religion which he describes as 'collective obsessive neurosis' and pleads for (European) society to renounce it and face the depths of human suffering.

Freud's later works were part of his arsenal against the increasing centrality of Jung within the international movement. Since Freud and Jung traversed the same ground and had strikingly different consequences for an Indian reflexivity on the question of religion, it is important to diverge here to discuss an element of Jung's encounter with Freud and India. Jung's position on religion and society was critically at odds with Freud's. With Jung, it can be argued there was a process of a literal 'projection' in the manner in which he posited the question of religion and civilization (read modernity). Jung saw the impoverishment of the (Western) 'soul' as a consequence of modernity. He posits in his works, the all-too-familiar oppositional duality of the material West and the spiritually rich east in an attempt to problematize and resolve the question of pessimism and civilization.[57]

In 1937, at the invitation of the British government Jung, visited India ostensibly to participate in the twenty-fifth anniversary celebrations of the Indian Science Congress at Calcutta University.[58] In Bombay, where

he first arrived, Jung headed straight out of the city in search of the 'real India' in the villages and temples. Bombay for him was a 'gigantic monotony of endlessly repeated life'.[59] 'India', he argued, 'seems so dreamlike: one gets pushed back into the unconscious, into the unredeemed, uncivilized, aboriginal world, of which we only dream, since our consciousness denies it. India represents the other way of civilizing man, the way without suppression, without violence, *without rationalism*.'[60] India was for Jung what it had been for many a romantic and orientalist for more than a hundred years, the mirror image of Europe. In Jung's case it became the assumptive framework for the now much vaunted 'holistic' psychotherapy. Jung called for the integration of Indian 'spirituality' whether it was not only the yogic or the Buddhist within psychoanalysis but also within the wider European ethos as a way out of the attendant pessimism of civilization. His choice of correspondents reflected his attitude, with Subramanya Iyer, the Guru to the Maharaja of Mysore, being one of the most long-standing correspondents.[61] Indian psychoanalysts, though numerous, were conspicuously absent in Jung's long list of correspondents. It was perhaps a mutual relationship. His travels to the temples were interspersed by the acceptance of many felicitations and honorary degrees that Jung received in India. Significantly, however, he was not invited to either the Indian Psychology Association or the Psychoanalytical Society and left neither mark nor mention in the *Indian Journal of Psychology*. For the Indian psychoanalysts, Jung was perhaps just a bad dream, only to be forgotten.[62]

Freud, by contrast, never travelled to India and resolutely looked within Europe. He viewed its civilizational salvation via an encounter with its underside that would ultimately reject religion while being completely dismissive of the saturated spirituality of India.[63] 'He was a true heir of the Enlightenment', Gay notes, in that 'Freud saw history as a great war between science and religion and rejected all compromise between the two contending forces.'[64] While it can be argued that romanticism was a constitutive part of the enlightenment, the issue for emphasis here is that the enlightenment tussle of science and religion acquired a different complexion in the Indian psychoanalytic tradition.

Soon after the publication of *Civilization and its Discontents*, Panchan Mitra warned against any simplistic posing of comparisons between Europe and India and further in seeing the 'primitive tribes of today as instances of survivals of earlier phases'. He argued not only that conditions were different but also for the dynamic nature of non-European cultures.[65] Prior to the Freudian reflection, however, the question of religion had been primary in Indian psychoanalytic discussions. In the

early 1920s and in the shadow of the anti-colonial non-cooperation and *Khilafat* movements, Berkeley–Hill presented a paper on *Hindu–Muslim Unity* in one of the meetings of the Psychoanalytic Society at which Gandhi himself was present.[66] Berkeley-Hill argued that there 'is very definite evidence that the emotional tone of the [communal] situation is over-determined ... [and that] Hindu Muslim relations [are] nothing more than rationalizations of excessive energy of unconscious origin'.[67] In an attempt to bring a scientific temper to the conundrum of violence in the name of religion, he argued for bringing to the fore the unconscious source of the hatred that, according to him characterized the relations between the two communities, to enable a resolution. He (somewhat disingenuously), pointed out that such hatred did not characterize Muslims living in other societies like China and that Hindus were rarely perturbed by cow-slaughter by Christians. Berkeley-Hill elaborated:

> the feeling of hatred which most Hindus experience for Muslim is derived from two sources: (1) The mother-land complex. (2) The Cow-totem. Through ravishing the mother the Muslim have won for themselves the kind of hatred which the Irish showed the English on account of England's attitude towards Ireland. By the destruction of the terrible cow-totem, the Muslim have encountered the fury that is the portion of every violater of a totem, not solely for violating the totem as well as for arousing those ambivalent feelings for the totem which are an integral feature of totem-worship.[68]

And in search of the transformative moment (in the psychoanalytic sense) Hill remarkably recommended a public ceremony where both the Muslims and Hindus would eat the ceremonial totem meal that is the cow.[69] While politically naïve, this explanation conformed to the preoccupations of the Indian psychoanalytical tradition, which at the outset was concerned to move psychoanalysis away from the domain of the individual to a psychoanalytic understanding of society. In other words, within the Indian engagement psychoanalysis was a grammar to be deployed to understand the social. In Berkeley-Hill, this deployment served to reiterate old assumptions and stereotypes in a new language and a new rationality.[70] Hill's Indian colleagues, on the other hand, stayed away from proffering psychoanalytic solutions while being considerably immersed in the question of religion.

In a close mapping of the chronology of Freudian concerns, Bose in 1930 articulated a critically different interpretation on religion and

society from that of Hill, Jung and Freud. He premised his understanding of religion by an interrogation of Hindu (or what he called Indian) philosophy by highlighting the dominance of 'psychological material within it'.[71] 'A psychologist', he said, 'was more in his elements in the domain of Indian philosophy, than in the province of Western thought'.[72] Thus locating and positioning his work within things Indian, this became a departure from his earlier theoretical differences with Freud, which were pitched within the classical analytical framework. Like Freud's later works which were written as a dialogue between an imaginary inquisitor or critic, Bose's work is framed as an investigative report in which the authorial voice is divided into two. The first authorial voice is designated as the 'hypothetical Enquirer' who trawls the classical Hindu canon for an understanding of the contemporary and the second – in the first person – addresses the scientific and the psychological while the presumed audience is either the uninitiated student or the critic. Bose argued that under 'the present rationalistic demand' Hindu philosophy – and specifically the *Upanishads* – could be divided into three types of questions that they addressed: those that were reasonable, then the mystical, and finally those of 'which absolutely no sense can be made out'.[73] He then assigned the 'hypothetical Enquirer' to uncover the 'prevailing obscurity' around classical texts in a bid to provide 'rationalistic' explanations to many a psychological dilemma around religion. In the first instance, to borrow Javed Majeed's phrase, he 'puts God in his place'.[74] Bose argued that 'man creates his God out of his own mental image' and that 'the heavenly father [was] a bigger prototype of the earthly father as an outcome of a projection of the unconscious'.[75]

While for Freud the psychoanalyzing of religion and its explanation meant a call for the end of religion, in Bose it became the starting point for an alternative idea of the mounting of difference with his European counterparts. He argued that an individual's relationship in the nature of pursuit for the godly etches out his selfhood. In negotiating that relationship, he explored types of encounters of the self with god via the division in the Gita of the *Sattva* (Knowledge), *Rajah* (Rule), and *Tamah* (Materialism). Thus, in this assertion of the meaning of the pursuit of god and by highlighting the various natures of that encounter, Bose underwrote his difference with Freud. As his work was located mostly in the relationship of the self with society, he also undermined the Jungian edifice of 'personality types'. In other words, the idea of selfhood for Bose (who did not use the word personality) was to be understood in its specific relation to the godly, which further facilitated for Bose a non-anthropological discussion of pantheism. By assuming the relation

of the self with god in its different manifestations, he argued that these different modalities of the self could be traced to the ancient and historical past with the arrival of related deities in appropriate epochs. He therefore identified the emergence of the deity *deshmata* as a reflection of the contemporary concerns (of the nation) or for that matter the emergence of the *sitala* (for the need to end smallpox). In other words, it was the expressivist unfolding (and development) of the self that determined for Bose the necessity of the religious with the societal and the individual.[76] In this context, religion served as a palliative for human suffering and was deemed therefore 'practical' for Bose rather than as the obsessive, collective neurosis that it was for Freud.

Bose could argue this because he was no true heir of the enlightenment. While, for Freud religion was of meaning only for the believer and for Jung the religious–spiritual was the quick-fix to the collective anxieties of the burden of civilization, for Bose religion 'permeated' the social but instead of explaining its causality, pathology or therapeutic need, he sought to deploy the psychoanalytic idiom to explain its implication with the self and society. He argued for the rationalistic interpretation of religion while simultaneously asserting the need to temper the scientific with an agnosticism towards the 'worst pitfalls of logic'.[77] Bose further contended that scientific curiosity was sanctioned by the religious scriptures and thus sought to justify the scientific by the religious.[78] The enlightenment dilemma of science versus religion was therefore a non-question for Bose. It is interesting to note that by the end of his article, having negotiated the religious and the scientific, the authorial voice becomes one. The co-existence of the religious with the scientific was as necessary as it was palliative and by posing and addressing it in the above fashion Bose was able to sidestep the stipulated enlightenment question of choosing science or religion with the expected (and demanded) rejection of the latter with an affirmation for the former.

Indian psychoanalysis was thus a hermeneutic exercise in that it was concerned with explanation rather than a study of causes of societal and individual pathology or its therapeutics. Further, Bose was not the sole mover, only the most prolific, and his ideas were shared by others in the Psychoanalytic Society.[79] Davar has argued that the Indian psychoanalytic engagement with classical–religious texts was a 'negotiation [to] strengthen alliances between the colonial rulers and the dominant Hindu philosophy'.[80] It is difficult to sustain a colonial connection with the Indian psychoanalytic engagement given its strategic distance from the colonial governmental. If the assumptive argument in Davar's paper

is that colonialism is everywhere which allows her to make the above connection, then it is far too broad to have any specific meaning. Given Bose's work, it is further difficult to sustain the view that 'Indian professionals did not contest the scientific foundation of western theory.'[81] Further, she argues that 'The possibilities of sciences offered more than religion, a façade of being secular' and apparently 'thrilled' Bose. It is hasty (as well as seductive) to read a secularist and/or a Hindu programme into Bose. It can only be repeated that given Bose's take on Freud and religion the issue of 'secularism' was a non-question. But in a desire to seek the rise of a political Hinduism in early colonial India (in a bid to explain the emergence of the Hindu Right in contemporary India) she is perhaps as guilty as the liberal–nationalist historians who etched the nation everywhere with scant historical rigour.[82] Further, it is the confusion and the lack of separating of colonial psychiatry from psychoanalysis that allows Davar to equivocate. Alternatively, Bose has been posited as being unoriginal in his English writings while reserving his 'creativity' for his Bengali writings.[83] This is equally misleading in that it sees the vernacular as a repository of some inrecuperable essential difference. It is misleading given that within Indian psychoanalysis the difference with the classical analytical was pitched at the centre of its theoretical assumptions with a selectivity that informed its points of engagement or rejection. Undeniably, by invoking the Hindu classical, it culturally restaged it. Significantly, it is instructive that Indian psychoanalysis and its high culture of difference did not – like other 'national sciences' such as chemistry – call for a 'Hindu Psychology'.[84] At the same time by mangling the given dichotomy and irreconcilability of the religious with the scientific, Indian psychoanalysis usurped the most enduring other of modernity, namely religion, by moving it out of the realm of the pathological (and spiritual) and into the realm of the explained and the normative.

## Struggles of selfhood: Nehru's tryst with Freud

Kakar has asserted that in the realm of the self, India lacks a 'psychological modernity' in the western sense given a subscription to a 'traditional concept of individuation'.[85] More recently, Partha Chatterjee has stated that India lacks a culture of the 'psychologised self'.[86] Rather than refuting these assertions by positing illustrations to the affirmative, there is a need to contextualize these within the history of Indian psychoanalysis. The failure of patterns in India that mirror the structuration of the self in Europe leads Kakar to fill an explanatory vacuum with the

invocation of 'tradition'. On the other hand, Chatterjee's claim makes sense if it is located as an answer to the issue of an absence of a culture of therapy on the couch in India. The previous section has discussed how Indian psychoanalysis, by deploying the investigative and methodological aspects (to the exclusion of the therapeutic) of the Freudian framework addressed the issue of the self in relation to society and religion. In this section, the ramifications of a psychologically minded introspection are discussed.

In the 1930s, outside the academy and the Psychoanalytical Society, Freud – or rather a 'popular Freudianism' – made its presence in Nehru's *Autobiography*.[87] Its fairly obvious Freudian elements have largely been ignored by most subsequent biographers and commentators.[88] This section will therefore address the salience of Freud for Nehru for an explication of the self.[89] By discussing an exemplary autobiography the aim is not to assert its well-known uniqueness but to highlight the manner in which Freud haunted a certain kind of modern.

Nehru's most recent biographer, Sunil Khilnani, recommends a few new arenas of inquiry in an attempt not to read the biography as a narration of the nation or as Nehru's own life history.[90] Khilnani lays down three alternative questions that would render a fresh understanding of Nehru's narration of the self. He identifies these as the slippage between intention and consequence, the articulation of a public and a private self and the making of a foremost political self with that of the nation.[91] This discussion will focus on the second of the above-mentioned issues. However, to somewhat alter the terms that Khilnani has used, it is argued that to make manifest the recurring Freudian referent within the autobiography, the terms 'inner' and 'outer' offer more potential to the concerns here rather than the 'private' and the 'public'. This is partly to sidestep the interpretative baggage associated with the concept of the 'public'.[92] Moreover, a discussion of the autobiography in terms of the private and the public will necessarily have to engage with the details of familial, conjugal and the political aspects of Nehru's self-narration that for the aims here cannot be accommodated. Instead, the focus will be on the arrangement of the autobiography and the manner in which Freud and the psychoanalytic idiom are deployed towards specific ends. Further, the emphasis will be on the theme of religion and the significance of Freudian understandings on the same for Nehru.

One of the key commentators and critics of psychoanalysis explains the reason why it captures a critical and unique space within disciplinary practices. Foucault argues,

> Whereas all the human sciences advance towards the unconscious only with their backs to it, waiting for it to unveil itself as fast as consciousness is analysed, as it were backwards, psychoanalysis, on the other hand, points directly towards it, with a deliberate purpose – not towards that which must rendered gradually more explicit by the progressive illumination of the implicit, but towards what is there, and yet is hidden.[93]

To extend the above, there is a close connection in the purposive strategies of an autobiography (and especially one that makes overt references to it) and psychoanalysis. While the writing of an autobiography – a recent (modern) invention – imposes a self-reflection, psychoanalysis by definition demands introspection and as such is turned at the outset towards the interior and the implicit. In other words, there is a convergence of the operative governing rules between them. It is precisely this turn to the inner (from the confines and seclusion of prison) while constantly negotiating the outer that becomes the leitmotif of the autobiography. This interplay between the inner and the outer is most acute, as will be seen, not only in discussions on religion but also foregrounded discussions on the expression of his own demeanour and 'personality'.[94] Nehru confesses that he had 'escaped' the 'diseases of civilization' including 'insanity' by a 'habit of introspection'.[95]

For Nehru, religion is something that hovers around and encircles the self-narration and significant effort is made at encountering it. The question of religion is posed in three possible sites that foreground Nehru's self-articulation and selfhood. Nehru selects his encounter with theosophy in his childhood as the first site (within the autobiography) in an attempt to delineate the place of religion within his sense of the self. At the age of thirteen he became a member of the Theosophical Society and was initiated by its leader Annie Besant and recounts his engagement with theosophy as an entrée into the world of scriptures and as a way of unravelling the 'mysteries of the world'.[96] However, without expounding further on it, Nehru quickly shifts the focus away from the significance of the religious texts and theosophy to a discussion and judgement on the identity of the theosophist. He arraigns theosophists for being 'ordinary folk' and for liking 'security better than risk' and goes on to censure his own theosophist past not only for the 'insipid look' that a sense of 'piety' induced in him but equally (as a consequence of being a theosophist) for having been 'thoroughly undesirable and unpleasant'.[97] This shift between a discussion on the nature and merits

of theosophy to the enlisting and judging of the disposition of the theosophists is mediated within the text with the first overt reference to Freud and psychoanalysis.[98] The psychoanalytic idiom within the autobiography is employed by Nehru both as a method to highlight and/or solve a conundrum but importantly the idiom becomes the vehicle that enables Nehru to constantly move between issues of concern and the nature and temperament of those he selects as representative of those concerns. In other words, throughout the autobiography there is a slippage and tension between an engagement with key questions (be it politics or religion) and certain key figures that Nehru selects as embodying those concerns. This juxtaposition between a critical attitude to the issues of the times with the mentalities of the different approaches of those implicated in societal issues is afforded and cohered by a strategic use of a vocabulary rooted in psychoanalysis and will be further elaborated upon in relation to Gandhi. However, before developing this theme further, it is necessary to ground the genealogy and attributes of Nehru's 'faith' and religion by turning to the second organizing element of the autobiography that also becomes the vantage point for Nehru to assess both religion and men of religious persuasion.[99]

Reflections on religion within the autobiography are posited in an oppositional relationship to Nehru's understanding of the role of science. The 'assurance of science' becomes the second and perhaps the most enduring referent for the expression of the self.[100] Faith, for Nehru was something that was encompassed by a notion of reason that was informed by the spirit of science.[101] While attempting to explain (and perhaps domesticate the significance of) communal conflagration in north India in the early 1920s, Nehru declared – unlike Indian psychoanalysts – that 'religious passions have little to do with reason'.[102] Earlier in the autobiography he writes pointedly that within a 'modern' definition of faith the approval of reason (via science) would provide the necessary safeguard against any idea of a 'blind' surrender to faith.[103] Contrary to other prevalent ideas both within public discussion and scientific engagement in late colonial India that had annexed the sphere of Hindu religion (and its scriptures in particular) to the imperatives of (western) science in part for 'securing the self-esteem of Indians', Nehru's efforts are directed at the demarcation and the limiting of the realm of religion.[104] This demarcation is sought both in relation to the political sphere and for an assertion of the self.

In addressing religion as a source of the self, Nehru invokes it only to evacuate its import for his selfhood explaining that 'Not having the religious temper and disliking the repressions of religion, it was

natural for me to seek some other standard.'[105] Broadly speaking that other standard for Nehru was science (and humanism) but significantly he partakes of Freudian understandings to explicate his position. In an attempt to explain but erase the religious thrust of political mobilization of the time (in specific relation to Gandhian non-violence) echoing Freud and prefacing an extract from the *Future of an Illusion* Nehru writes;

> If we are to find a way out of the crisis of the spirit and realise what are the true spiritual values to-day, we shall have to face the issues frankly and boldly and not take refuge under the dogmas of any religion. What religion says may be good or bad, but the way it says it and wants us to believe it is certainly not conducive to an intellectual consideration of any problem.[106]

As discussed in the previous section, Freud had professed the need for the renunciation of religion as a way out of an acknowledged civilizational crisis that had engulfed Western Europe in the aftermath of the First World War. Rather than calling for its repudiation, Nehru highlights instead the incapacity of religion to address contemporary crises. In keeping with his belief in the rational-scientific he chastises religion for its (assumed) failure to converse with the scientific temper of the twentieth century. For Nehru, religion and science belonged to two separate explanatory domains that had few, if any, common meeting points. Describing Mohamad Ali, for example, Nehru wrote, 'he was deeply and as I considered, most *irrationally religious*'.[107] Nehru articulates his avoidance of discussing religion with Ali so as not to cause friction but mainly because he 'always [found] it a difficult subject to discuss with believers of any creed'.[108] Like Freud, religion for Nehru was of meaning only for the believer. Unlike Freud, however, he stops short of considering it a 'delusion' that required rejection. Engaging simultaneously with questions Indian and (perhaps answers) Western, Nehru summarizes religion and recognizes the 'delusional' on an altogether different aspect (and it is worth quoting at length for the purposes here):

> What then is religion (to use the term in spite of its obvious disadvantages)? Probably it consists of the inner development of the individual, the evolution of his consciousness which is considered good . . . as far as I understand it, religion lays stress on this inner change and considers outward change as the projection of this inner development. There can be no doubt that this inner development powerfully

> influences the outer environment . . . Both act and interact on each other. It is a commonplace that that in the modern industrial West outward development has far out-stripped the inner, but it does not follow, as many people in the East appear to imagine, that because we are industrially backward and our external development has been slow, therefore our inner evolution has been greater. That is one of the delusions with which we try to comfort ourselves and try to overcome our feeling of inferiority.[109]

In the first instance (like the rest of the autobiography) the above extract is peppered with a psychoanalytic lexicon. Though terms like consciousness, delusions, projection, or inferiority have in the late twentieth century become an integral part of everyday speech; their use by Nehru in the early 1930s is nevertheless striking. Importantly, unlike Bose who had deployed (and revised) psychoanalytic ideas to highlight the necessary implication of religion in the expression of the self (the inner) in relation to society (the outer), Nehru while structuring his ideas with a psychoanalytic language, seeks to position the place of religion primarily in the province of the inner.[110] Nehru goes on to dismiss the potential of the 'inner' to overcome crises and refuses to harness it as a salvaging consequence of the lack of industrialization or as a recuperation from the effects of being colonized. Instead he stresses the primacy of the outer declaring that a 'certain measure of external development is essential before the inner evolution can take place'.[111]

Further, it is not only that Nehru has recourse to Freud and his vocabulary but also equally Nehru (like Freud) places his pessimism regarding the spirit of the times at the door of religion. Repeatedly, he points to religion as the basis of his 'accumulated irritation'.[112] While on occasion he castigates religion and its essence for being 'killjoys', on another he condemns it not only for the violence committed in its name but also its 'peaceful garb . . . [that] outrages the mind and crushes the spirit and breaks the heart'.[113] This dejection is at its most articulate in the autobiography in the narration of Nehru's relationship with Gandhi and a discussion of this interface will help conclude the issues raised here.[114]

The primacy and the potential of the 'inner' was one of the central tenets of Gandhian politics that had repeatedly called for its self-discipline to enable the reconstitution of a national society, within which the religious idiom was mobilized.[115] It is precisely over this primacy of the 'inner' over the 'outer' that Nehru distances himself from Gandhi:

> Gandhi wants to improve the individual internally, morally and spiritually, and thereby to change the external environment. He wants people to give up bad habits and indulgences to become pure . . . But can there be any doubt even from the individual point of view and much more so from the social, these failings are less harmful than . . . the ruthless struggles of groups and classes, the inhuman suppression and exploitation of one group by another, the terrible wars between nations?[116]

Further, as a riposte to the Gandhian call for celibacy for the making of a new national self, Nehru once again has recourse to Freud arguing, 'In these days of the Oedipus complex and the spread of psychoanalytical ideas this emphatic statement of belief [on celibacy] sounds strange and distant . . . Gandhi is absolutely wrong on this matter.'[117]

The civil disobedience movement and its aftermath brought the fundamental difference between himself and Gandhi into sharp relief for Nehru.[118] While he repeatedly asserts that he found it 'difficult to understand' Gandhi, he nevertheless recognized him as the 'quintessence of the conscious and subconscious will of millions'.[119] Nehru explains his difficulty as the 'metaphysical' nature of Gandhian politics that had nevertheless captivated the 'masses'.[120] While ideologically removed from Gandhi, Nehru recognized the centrality and efficacy of Gandhi in the national arena.[121] This ambivalence informed Nehru's questioning of his own selfhood and role and in the chapter of his autobiography on religion, he articulates his estrangement: 'I felt lonely . . . Was it my fault that I could not enter into the spirit and ways of thinking of my countrymen?'[122] This dejection, however, gave way to a reassertion in his belief in the rational–scientific. The Bihar earthquake of 1934 became a turning point in Nehru's relationship with Gandhi, in the manner in which, at least within the autobiography, a stridency informs the articulation of 'temperamental differences' between the two. Gandhi had explained the disaster as a 'punishment for the sin of untouchability'.[123] Acknowledging that the dogmas of science had of late been tempered by the study of the 'effect of emotional states and psychic occurrences on matter', Nehru goes on to dismiss Gandhi's explanation from both the scientific and the psychological standpoint, for its 'astounding' belief in Providence.[124]

In the last instance, while disagreeing with (and perhaps disappointed by) Gandhi's blurring of the realms of the religious, political and social – as much as on the importance of all that was understood to constitute the 'inner' – Nehru also pitched his own understanding on the nature of

selfhood both on the scientific and the psychological planes. A search for the 'tracing' of 'mental outlook' had informed the ambition of the writing of the autobiography. Towards the end, Nehru writes emphatically, 'How indeed does character develop? Gandhiji has been compared to the medieval Christian saints [by Verrier Elwin], and much that he says seems to fit in with this. *It does not fit in at all with modern psychological experience and method*.'[125]

This repeated deployment of the psychological enabled Nehru to stress his distance with Gandhi but equally became the loose scaffold through which the inner and the outer were negotiated. The question of religion also proved to be as inescapable for Freud as it was in late colonial India. Significantly, Freud and his vocabulary offered the potential for an understanding of the nature of contemporary times, both for practising Indian psychoanalysts and for public figures like Nehru, though in strikingly different ways. Nehru tapped into what John Forrester has explained as 'Freud's ineluctable presence as the climate of opinion' that afforded the use of Freud in both a diffused and a specific manner for the expression of the self.[126] It is thus the diffused Freudianism that underpins the autobiography with a liberal use of the psychoanalytic vocabulary that can be gleaned from the constant preoccupation with personality-traits, temperament and psychological types that interlopes the autobiography.[127] Simultaneously, Freudian understandings of religion are invoked within the autobiography to buttress claims for the 'rational' rejection of religion.

Not simply a derivative exercise, psychoanalysis in late colonial India was a reflexive process of appropriation. Part of the impetus was derived from Freud himself in the manner in which his writings were informed by an internal critique of the modern condition. This animated an Indian tradition, which simultaneously underwrote its difference with it. Significant attempts were made by Indian psychoanalysts like Bose to make psychoanalysis converse with things Indian. In the process, Freudian ideas became primarily a grammar for explanation, perhaps to the exclusion of their therapeutic potential. Simultaneously Jung's belief in India as an irreducibly different realm was, significantly, rejected.

Bose and Nehru offer two opposite exemplars of the engagement with Freud. Whereas Bose revised the key tenets of Freud's work via interpretative strategies to articulate religion as a form of rationality, Nehru applied Freud uncritically as a weapon in his own desire to separate religion from politics. Just as the encounter with India defined the intellectual division between Freud and Jung, so the use of Freud became a device for Nehru to distance himself from Gandhi. Nevertheless in

their different ways, both Bose and Nehru played their part in propelling psychoanalysis into public discussion. Its hermeneutic potential was deployed as a vocabulary in a bid to explain modernity, specifically on questions of religion and selfhood. Its appeal further pervaded the negotiation of the dilemmas and the fashioning of a modern self in the case of Nehru. The irony was that the dissemination of Bose's striking ideas had less impact than the introspective but very widely read reflections of Nehru.

## Notes

1. The term 'godless' is borrowed from Peter Gay in *A Godless Jew: Freud, Atheism and the Making of Psychoanalysis* (New Haven: 1987).
2. J. Rose, 'Freud in the "Tropics"', *History Workshop Journal*, 47 (Spring: 1999) 51.
3. C. Hartnack, 'Vishnu on Freud's Desk: Psychoanalysis in Colonial India', in T. G. Vaidyanathan and Jeffrey J. Kirpal (eds), *Vishnu on Freud's Desk: A Reader in Psychoanalysis and Hinduism* (Delhi: 1999), p. 97.
4. Throughout this article, psychology will refer to the broader aspects of the discipline of psychoanalysis. As will become clear, not all contributors to a psychoanalytic-minded discussion were strictly speaking psychoanalysts. Conversely, a lot of discussion on psychoanalysis was conducted under the rubric of psychology.
5. Jawaharlal Nehru, *An Autobiography* first published from London in 1936. Twelfth edition (New Delhi: 1998) used here.
6. Mahendra Lal Sircar, *On the Physiological Basis of Psychology* (Calcutta: 1870).
7. Sircar, *Physiological*, pp. 2, 18.
8. Shruti Kapila, 'The Making of Colonial Psychiatry, Bombay Presidency, 1849–1940' (unpublished Ph.D. thesis, University of London, 2002), pp. 215–19.
9. For Sircar's life history, see, Sarat Chandra Ghosh, *Life of Dr. Mahendra Lal Sircar* (Calcutta, 2nd edition, 1935). Also David Arnold, *Science, Technology and Medicine in Colonial India* (Cambridge: 2000), pp. 58–9, 163, 176. It would seem that Sircar held a continuing interest in psychology, as he readdressed these issues two decades later in *Moral Influence of Physical Science* (Calcutta: 1892).
10. Durganand Sinha, *Psychology in a Third World Country: The Indian Experience* (New Delhi: 1986), p. 14.
11. Amit Ranjan Basu, 'The Coming of Psychoanalysis in Colonial India: The Bengali Writings of Dr. Girindrasekhar Bose', Enreca Occasional Papers Series, 5, Tapati Guha Thakurta (ed.), *Culture and the Disciplines: Papers from the Cultural Studies Workshops* (Calcutta: 1999), p. 37.
12. Sinha, *Psychology*, pp. 11–19.
13. Kapila, 'Making of Colonial Psychiatry', pp. 226–27.
14. Arnold, *Science*, p. 129.
15. Partha Chatterjee, 'The Disciplines in Colonial Bengal', Partha Chatterjee (ed.), *Texts of Power* (Calcutta: 1996), pp. 11–20.

16. Arnold, *Science*, p. 159.
17. The formative moment of this culture can be located with Sircar's founding of the Indian Association for the Cultivation of Science in 1876. Arnold, *Science*, pp. 129–68.
18. Report on the First Annual Congress, Bombay, *Indian Journal of Psychology* (hereafter *IJP)*, 1, 1 (1926) 133.
19. 'Mental Hygiene', Presidential address to Indian Science Congress Psychology Section, 1927, *IJP*, 2, 1 (1927) 1.
20. Girindrasekhar Bose, *The Concept of Repression* (London: 1921).
21. Freud to Andreas-Salome, E. Pfeiffer (ed.), *Sigmund Freud and Lou Andreas Salome* (London: 1972), p. 114.
22. Ashis Nandy interprets this visual encounter as a signifier of a colonised mind set. See Ashis Nandy, 'The Savage Freud: The First Non-Western Psychoanalyst in Colonial India', *The Savage Freud and other Essays* (Delhi: 1995), pp. 116–17.
23. Ernest Jones, 'Minutes of Business Meeting, Seventh International Psychoanalytical Congress, Berlin 1922', *IJP*, 4, 1 (1923) 236.
24. Nandy, *Savage*, p. 114.
25. Sailendra Krishna law, 'Girindrasekhar Bose', Special Issue on Bose, *Samiksha* (1955), p. 9 cited in C. Hartnack, *Vishnu,* pp. 83–4. I have taken Dipesh Chakrabarty's translation of the term *adda* from his *Provincializing Europe: Postcolonial Thought and Historical Difference* (Princeton: 2000), p. 180.
26. The literal translation of the term *Utkendra* is given as of circles, not having the axis to the centre. See, M. Ali, M. Moniruzzaman, and J. Tarique (eds), *Bengali to English Dictionary* (Bangla Academy, Dhaka: 1996), p. 75.
27. For a refreshing and insightful discussion of the context, meaning and history of *adda* as social practice in relation to an Indian modernity see Dipesh Chakrabarty, '*Adda*: A History of Sociality', in his *Provincializing*, pp. 180–213.
28. Hartnack, *Vishnu*, p. 85.
29. Chakrabarty, *Provincializing*, p. 180.
30. This is especially significant given that there was an overlap in membership between the Psychology Association and the Psychoanalytic Society. To illustrate, of the most prominent Bose, Berkeley-Hill and Haldar were members of both organizations.
31. Dipesh Chakrabarty, *Provincializing*, pp. 195, 199. He argues that the interconnectivity between sociality and communication was constitutive of the 'dissemination of ... taste'.
32. Kapila, 'Making of Colonial Psychiatry'.
33. For an analogous discussion of the everyday but significant cultural changes in Bombay see, Frank Conlon, 'Dining Out in Bombay' in Carol Breckenridge (ed.), *Consuming Modernity: Public Culture in a South Asian World* (Minneapolis: 1995), pp. 90–127.
34. On the role of formal and informal bodies for the dissemination of scientific ideas see Irfan S. Habib, 'Institutional Efforts: Popularization of Science in the Mid 19th Century', *Fundamenta Scientiae*, 6, 4 (1985) 299–312.
35. G. Bose, 'Psychology and Psychiatry' paper read at the Symposium held by the Indian Science Congress at Calcutta, 1928, *IJP*, 4, 4 (1931) 143.

36. N. N. Sengupta, 'Psychology, its Present Development and Outlook', *IJP,* 1,1 (1926) 19.
37. Ibid., p. 24.
38. Ibid., p. 6.
39. Ibid., p. 18.
40. Freud first used the word psychoanalysis in 1896 in 'Heredity and Aetiology of the Neuroses' (in French) and expanded its meaning and use in *The Interpretation of Dreams* first published in early 1900. For an exhaustive account of Freud and his work see Peter Gay, *Freud: A Life of Our Time* (London: 1988).
41. Suhrit Chandra Mitra, 'Suggestions for a New Theory of Emotions', *IJP*, 8, 1, 2&3 (1933) 19. Mitra was a member of both the Indian Psychology Association and Psychoanalytic Society. He wrote extensively on psychoanalytic theory. Some of his works include 'The Concept of Instinct', *IJP*, 3, 1 (1928) 45–87, 'Psychology and Life', *IJP*, 10, 1&2 (1935) 108–24.
42. Girindrasekhar Bose, *Concept*.
43. Girindrasekhar Bose, 'A New Theory of Mental Life', *IJP,* 8, 1, 2&3 (1933) 86–157. The seesaw mechanism entailed each opposing set of desire to be made part of the conscious and in the process of it being made conscious, the client would be rid of the attenuated anxiety. See 'Illustrative Cases' in the same article.
44. Ibid., p. 86.
45. Hartnack, 'Vishnu', pp. 98–101.
46. Girindrasekhar Bose, 'The Genesis and Adjustment of the Oedipus Wish' (1928), reprinted in *Vishnu*, pp. 21–38. For an appraisal of the problematic of Freud's relationship with his female clients see Lisa Appignanesi and John Forrester, *Freud's Women* (London: 1993).
47. Bose, 'Genesis'. Bose's key point of critique was the relative absence of the 'castration threat' amongst his own clients that Freud had identified. C.D. Daly who was a member of the Indian association and a correspondent of Freud's had earlier identified the same via a study of Hindu myths in 'Hindu-Mythologie und Kastrationkomplex' translated by Peter Mendelsohn *Imago*, 13 (1927) 145–98.
48. See, for instance, A. K. Ramanujan, 'The Indian Oedipus', Lowell Edmunds and Alan Dundes (eds), *Oedipus: A Folklore Casebook* (New York: 1983), pp. 235–61, and Paul B. Courtright, *Ganesa: Lord of Obstacles, Lord of Beginnings* (Oxford: 1985).
49. Jacqueline Rose, 'Freud', pp. 49–67.
50. He declared himself a 'godless Jew' to his friend Oskar Pfister hinting thereby his atheism on the one hand but the presence of a Judaic culture in his upbringing on the other. Freud's clinical work that brought out aspects of religion includes the case-histories of the Wolf Man and the Rat Man. For a discussion of Freud and religion within the European context see Gay, *A Godless Jew*.
51. 'Obsessive Actions and Religious Practices' (1907), Peter Gay (ed.), *The Freud Reader* (London: 1995), pp. 429–35.
52. Sigmund Freud, *The Future of an Illusion* (1927) in *Civilization, Society and Religion* The Pelican Freud Library (PFL), 12 (London: 1985). On the issue of a scientific interpretation of religion in Freud's work see D. Black, 'What

Sort of a Thing is a Religion? A View from Object–Relations Theory' *IJP*, 74 (1993) 613–25.

53. Freud, *Future*, p. 221.
54. Religious doctrines for Freud were illusions and bore a close relationship to delusions. Ibid., p. 212.
55. In relation to colonial psychiatry, Kapila, 'Making', pp. 178–220. For a more general historical discussion of the term, see George W. Stocking, *Victorian Anthropology* (New York: 1987).
56. He reiterated these ideas 3 years later in *Civilization and its Discontents* (1927), translated by Joan Riviere (New York: 1994). This work is often seen as the most representative and most quoted of the later Freud. Freud wrote this work in the shadow of the advancing power of the Nazi regime, and a pessimism about human nature underwrites what many commentators have described as a Hobbesian piece.
57. C. G. Jung, *Civilization in Transition*, Bollingen Series, XX, Translated by R. F. C. Hull (London: 1964). See especially, 'The Spiritual Problem of Modern Man' (1931), pp. 74–98.
58. Frank McLynn, *Carl Gustav Jung* (London: 1996), pp. 398–415.
59. Jung, 'The Dream Like World of India' (1939), *Civilization*, p. 517. He further described the city and its inhabitants as, 'Human life appears to be flimsy in every respect. The native town of Bombay seems to be a jumble of incidentally piled-up human habitations. The people carry on an apparently meaningless life, eagerly, busily, noisily. They die and are born in ceaseless waves, always much the same.' Ibid., pp. 516–17.
60. Jung, 'What India can Teach Us' (1939), *Civilization*, p. 528. Emphasis added.
61. Gerhard Adler (ed.), *C. G. Jung, Letters, 1906–1950, Vol. 1* (London: 1973).
62. Simultaneously, it is instructive to note that Jung became paradigmatic of mid-twentieth-century Indology. See Ronald Inden, *Imagining* India (Oxford: 1990), pp. 85–130.
63. Freud, *Civilization*, p. 13.
64. Gay, *Freud Reader*, p. 685.
65. Panchan Mitra, 'Psychology of Cultural Change', *IJP*, 7, 3&4 (1932) 105–6.
66. Owen Berkeley-Hill, 'Hindu Muslim Unity' Read before the Indian Psycho-analytical Society, 1924, *Collected Works* (Calcutta: 1933), pp. 149–56.
67. Ibid., pp. 149–50.
68. Berkeley-Hill, 'Hindu', pp. 155–6.
69. Ibid. p. 156.
70. It was perhaps Berkeley-Hill's location and entrenchment with the colonial–official edifice that disallowed him (despite his psychoanalytic training) to take into account the deeply political nature of the strife between the two communities. He took the colonial refuge in the typical by asserting the inherent incompatibility of the two religions.
71. Girindrasekhar Bose, 'The Psychological Outlook in Hindu Philosophy', *IJP*, 5, 3&4 (1930) 120.
72. Ibid.
73. Ibid., pp. 121–2.
74. Javed Majeed, 'Putting God in His Place: Bradley, McTaggart and Iqbal', *Journal of Islamic Studies*, 4 (1993) 208–36.
75. Bose, 'Psychological', p. 124.

76. Ibid., pp. 138–43.
77. Ibid., p. 127.
78. Ibid., p. 124
79. Through the decade, the difference between the Indian psychoanalytic rendition of religion with that with Freud was discussed though not always with the same range of insight as that of Bose. See, B. Sen, 'The Standpoint of Religious Psychology', *IJP*, 10, 1, 2&3 (1935) 119–26; N. R. Amenchelra, 'Another View of Religion', *IJP*, 11, 3&4 (1936) 237–45; S. C. Chatterjee, 'Freud on the Future of Religion', *IJP*, 15, 4 (1940) 135–45, or Bose's own restatement, 'An Aspect of Freudian Thought', *IJP*, 15, 4 (1940) 97–108.
80. Bhargavi V. Davar, 'Colonialism, Caste and Gender in Indian Psychiatry: A Preliminary Investigation', Paper presented at the 16th European Meeting of South Asian Studies, Edinburgh (September 2000), p. 2.
81. Ibid., p. 3.
82. This is not to argue against her politics but to assert the need to historically and intellectually locate the Indian psychoanalytical endeavour.
83. Nandy, *Savage Freud*, p. 114.
84. For a discussion of the interlocking of science with Hinduism, in relation to both the narrative of the nation and the colonial, see David Arnold, *Science*, pp. 169–21.
85. Sudhir Kakar, 'Clinical work and Cultural Imagination', *Vishnu*, p. 230.
86. Partha Chatterjee, Closing comments, SOAS South Asian Life-Histories Conference, London, May 2000.
87. Jawaharlal Nehru, *An Autobiography* (1936), 12th edition (New Delhi: 1998). This is not to assert that this was the only form that popular Freudianism acquired in the first half of twentieth-century India. Literature, was a particularly fertile ground for it, Tagore's *Gora* being an obvious example. Though a key aspect and an unexplored arena in Indian history, Popular Freudianism can only be dealt with in a highly selective manner here.
88. It is interesting that there has been no psycho-history attempted on the life of Nehru in the way it has been done in Gandhi's case by Erik Erikson, *Gandhi's Truth: On the Origins of Militant Non-Violence* (London: 1969).
89. B. R. Nanda, *Jawaharlal Nehru: Rebel and Statesman* (Delhi: 1995).
90. Sunil Khilnani, 'Nehru's Nehru: The Uses of Autobiography', Paper presented at SOAS South Asian Life-Histories Conference, London, May 2000.
91. Ibid.
92. Jurgen Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (Cambridge: 1994). On the debate over the applicability of the concept of the public sphere in colonial India see, *South Asia* (1993), Special Issue.
93. Michel Foucault, *The Order of Things An Archaeology of Human Sciences* (London: 1997), p. 374.
94. Nehru, *Autobiography*, Nehru reflects on the nature of his appeal and leadership see especially, pp. 201–8.
95. Nehru, *Autobiography*, pp. 204 and 93. Nehru highlights further the importance of exercise for its 'psychological value', passim, pp. 396–7. On the fear of insanity as a consequence of confinement, see also, p. 222.
96. Nehru, *Autobiography*, p. 15.

97. Ibid., p. 16. Nehru reiterates the importance of risk over security writing, 'risk and adventure fascinated me; I was always like my father, a bit of a gambler . . . with the bigger issues of life', p. 20.
98. Nehru describes an archetypal dream of flying that he describes as being a 'frequent one throughout [his] life' and wonders at its Freudian interpretation. Ibid., p. 15.
99. Nehru judges the temperament and 'personality' by deploying the terminology of psychology among others Khan Abdul Gaffar Khan, Madan Mohan Malviya and goes on to stress the appeal of Buddhism for him because of Gautam Buddha's personality. Ibid., pp. 279, 158, 271 respectively.
100. Nehru emphasises the confidence of late nineteenth- and early twentieth-century science, *Autobiography*, p. 22.
101. Nehru, *Autobiography*, pp. 21–2.
102. Ibid., p. 135.
103. Ibid., p. 21.
104. David Arnold, *Science*, p. 170. On the Nature of Hindu Science see pp. 169–210.
105. This statement is made in the context of a discussion on sex and disavowing a notion of sin as received from religion. Nehru writes in relation to sex, 'Most of us were strongly attracted by sex, and I doubt if any of us attached an idea of sin to it. Certainly I did not, there was no religious inhibition', Nehru, *Autobiography*, p. 20.
106. Nehru, *Autobiography*, p. 550.
107. Ibid., p. 117, emphasis added.
108. Ibid., p. 118. Nehru goes on to write, 'he insisted on discussing religion with me. I tried to dissuade him, pointing out that our view-points were very different, and we were not likely to make much impression on each other', p. 119.
109. Nehru, *Autobiography*, p. 379.
110. In the chapter entitled 'What is religion?' Nehru calls for more 'precise' terminology to discuss religion since the terms religion according to him invoked 'strong emotional response which . . . make dispassionate consideration impossible', p. 378.
111. Ibid.
112. Nehru, *Autobiography*, p. 507.
113. Ibid., pp. 141 and 508.
114. Rather than addressing the various issues that underpinned the inter-relationship between Nehru and Gandhi (or indeed the various strands of Gandhian and Nehruvian ideas that have defined twentieth-century Indian politics), this discussion via an internal reading of the autobiography will focus on the manner in which Nehru explains his relationship with Gandhi, an explanation that was in part enabled by psychoanalysis.
115. Uday Singh Mehta, *Empire and Liberalism: A Study in Nineteenth-Century Liberal Thought* (Chicago: 1999) argues that Gandhi's emphasis was on the forming of an 'ethical community' rather than nationalism, pp. 106–14.
116. Nehru, *Autobiography*, p. 521.
117. Ibid., p. 513.
118. Nehru, *Autobiography*, pp. 209–16, 249–59.
119. Ibid., p. 253.

120. Ibid., p. 289.
121. David Arnold, *Science*, pp. 206–7. Nehru, *Autobiography*, pp. 481–92.
122. Nehru, *Autobiography*, p. 374.
123. Ibid., p. 490.
124. Ibid.
125. Ibid., p. 509. Emphasis added. Earlier he chastises Gandhi's lack of a scientific temperament, writing 'Gandhiji lays all stress on character and attaches too little importance to intellectual training and development'.
126. John Forrester, *Dispatches from the Freud Wars: Psychoanalysis and its Passions* (Cambridge, Mass.: 1997), p. 207.
127. Nehru, *Autobiography*, pp. 15, 65–8.

# 7

# Mapother of the Maudsley and Psychiatry at the End of the Raj

*James H. Mills and Sanjeev Jain*

## Introduction

In 1937 Professor Edward Mapother took a trip to Ceylon. Mapother was the Medical Superintendent of the Maudsley Hospital in London. The oldest of seven siblings, and the son of an ENT surgeon, Mapother had his initial training in Dublin. After the First World War he had been entrusted with reforming psychiatric services in London. He set about pushing through changes in legislation and developing the wards of the London County Asylum, establishing neuro-psychiatric clinics and placing the emphasis on early treatment. The result was perceived as a shift from a legalistic and custodial system to a clinical one that emphasised the latest in psychiatric theory. Chief among his innovations was the Institute of Psychiatry at the Maudsley Hospital in London.[1] This was designed as a remedy for what Mapother described as the 'absurd situation that if English speaking psychiatrists want to specialise they have to go to Germany or Austria, especially Vienna (since they teach in English)' and his vision was of 'an institute to provide for research and for the very advanced training of psychiatrists and of most English speaking psychiatrists on leave from India and from the various British Overseas Dominions'.[2]

Mapother was invited to Ceylon by Dr S.T. Gunasekara, who by 1936 was the first Ceylonese Medical Director of the island.[3] He wrote in 1937 that in a meeting:

> with the minister for health I mentioned your name knowing your reputation and how keenly you are interested in the subject. I am writing this demi-officially to enquire whether you could see your way to come out to Ceylon, and if so, when and for what length of

time. I shall be glad if you would also let me know the terms under which you could come'.[4]

Gunasekara was the recipient of a Rockefeller Foundation scholarship which he spent in London,[5] and Mapother enjoyed a long relationship with the Foundation that stretched from the 1920s until his death in 1941.[6] It is likely that it was this connection which put the Maudsley psychiatrist uppermost in the mind of the new Medical Director of Ceylon when he turned his attention to the mental health of the island.

The result of this trip was to be a series of documents that provide a snapshot of psychiatry in south Asia in the years before the Second World War and the subsequent end of the British Empire. This chapter will consider Mapother's reports from a number of perspectives. In the first place it looks at the politics of his trip, and the reasons that an outsider was invited into a colonial medical system. It seems clear that his inspections and reports were organised as a direct challenge to the colonial state, and were intended to force it into policy decisions it was unlikely or unwilling to take of its own accord. In the second place, it examines the evidence of psychiatric practices in south Asia in the period before decolonisation. Psychiatry had often been lauded as among the benefits of imperialism and its introduction of modern scientific and medical techniques. Mapother's observations allow the historian to assess how effectively the British had implemented psychiatric practices.

## Psychiatry in South Asia

British colonial administrators had established specialist institutions for those they considered 'insane' in both local and European communities from the eighteenth century onwards in south Asia. At first these seemed to be little more than places of segregation and isolation, but as the nineteenth century progressed attempts to provide therapy based on European models became more complex and concerted. By the 1860s it was common to find superintendents expressing the opinion that, 'I hope that we shall be able to carry out still further improvements, and in time bring the Asylum as near to the English standard as the circumstances of the country admits',[7] while those nearer the top of the colonial bureaucracy also recognised that 'everything that constitutes a remedial institution on the modern European footing has to be introduced and exercised for the first time'.[8] Throughout this period the

asylum system was funded by the colonial state and each hospital was headed by a European doctor working for the Indian Medical Service (IMS), although the staff at the hospitals were usually drawn entirely from the local community.[9]

This began to change in the twentieth century. The state-run hospitals of the colonial system experienced a lack of European medical personnel during, and in the wake of, the First World War. The effect was the 'Indianisation' of the health services so that it was now doctors of local origin who took control of facilities.[10] Outside of these institutions Christiane Hartnack has shown that modern Western theories of mental health and therapy were beginning to circulate in society and that even such innovations as Freudian analysis found a local market.[11]

The period in which Edward Mapother arrived in south Asia in the 1930s was a particularly complex one that has been relatively neglected in accounts of colonial medicine. The latter has been accused of simply serving as a 'tool of empire',[12] where 'the history of medicine in empire refers to the ... history of medical regimes as participants in the expansion and consolidation of political rule'.[13] Such an impression usually relies on evidence from the nineteenth century and the focus here on Mapother's visit in the decade before the end of Empire in south Asia provides an insight into the rather more complicated power relations of medicine in this period.

## Mapother in Asia

Edward Mapother provided the following account of the circumstances of his visit in the official report submitted to the Government of Ceylon in 1938.[14]

> The inadequacy of the provision for mental disorder in Ceylon and the deficiencies of such treatment as has been provided has been a subject of criticism for a number of years. During a visit to Ceylon in January 1937 some of those who felt strongly about the matter asked me to visit Angoda Asylum. The impression produced was such that when subsequently I received from the Government of Ceylon an invitation to give an opinion upon necessary reorganization, I was glad of the opportunity.[15]

While this is the only account of the origins of his trip to Ceylon, other sources written after the journey provide some other details. Mapother himself noted in a letter in 1937 that:

> I am venturing to send you another copy of my Ceylon Report in the hopes that you might get Dr Gregg to look over it at his leisure. It has raised hell in the Island (vide cuttings from local press) and various parties from the Ministry of Health downwards are briskly engaged in passing this from one to the other. What is more important they seem agog to do something quick. It seemed to me one of the cases where forcible methods seemed most likely to be successful.[16]

Another letter in his correspondence provides more information. In a letter to Mapother written in September 1938 John Pye, a member of the European Association of Ceylon, wrote:

> There can be no doubt whatever that your report has done splendid work in making the Government and the country realise the terrible state into which the Department dealing with mental cases had fallen. I am afraid that until your report, which has now been published as a Sessional paper, none except the one or two of us who had to visit the place, including the Government themselves, really knew how terrible was the treatment afforded to mental cases.[17]

When taken together, these details provide glimpses of a picture of the circumstances of his involvement in Ceylon. It seems that while visiting the island those living locally who felt strongly about the provision of psychiatry there, probably those involved in some capacity as 'visitors', took the opportunity to avail themselves of an 'expert' to assess what they had encountered. Mapother thereafter seems to have taken it upon himself to create a fuss about the facilities, a fuss that had made it into the newspapers and which had pressured the colonial government to act. Whether Dr Gunasekara was in collusion with those critics of the government is unclear, but it was certainly the case that his relations with British superiors had been uneasy in the past.[18] He acted by approaching Mapother to return to the island in a demi-official capacity and to make recommendations as to how the system might be improved. At no point does the impression form, from the above, that it was the government itself which took the initiative to have Mapother visit the island in the first place. It seems as if the government had little interest in the psychiatric facilities under their control, and were simply responding to criticism in their eventual strategy.[19]

While the visit of Mapother to Ceylon had forced the government to act and to appoint him in an official capacity as an 'expert' assessor and inspector, it had further unforeseen consequences in unleashing

him on the rest of south Asia. Having been asked back by the island's government, he decided that 'in order to qualify myself for giving advice of a practical kind, I suggested that I should make a preliminary inquiry into the mental arrangements of various Provinces of India'.[20] As such he took off to Ceylon's neighbour, packing in visits to hospitals as far apart as Bombay, Madras, Lahore and Ranchi. As well as visiting seven of India's psychiatric units he attended the Indian Science Congress at Calcutta and interviewed a number of officers in the colonial medical service, including the Director-General of the IMS himself.

Significantly, however, the Government of India was careful to make it clear that, while it was happy to help him out in whatever ways it could, his was not an official visit. Mapother had agreed in a meeting with the President of the Medical Board at the India Office that 'the information which I obtained was not for publication, but for personal use in relation to the report which I was preparing for the Government of Ceylon as to the reorganisation of the Island'.[21] Indeed, this was emphasised in newspaper reports, one clipping stating that 'Dr Edward Mapother in an interview to *The Hindu*, stated that he was in India on a holiday tour'.[22] It seems that the Government of India was not about to be caught out as had its equivalent in Ceylon. While the latter was forced to publish his criticisms and recommendations, and to commit itself to reforms, the assessment of Mapother of India's system remained a private typescript that sits unpublished in his private papers to this day.

## Mapother's reports

Edward Mapother was unequivocal in his assessment of the psychiatric facilities of the Government of Ceylon, and in his view of the implications of this assessment. He made it plain that the 'inquiry in Ceylon reveals such a state of affairs that to acquiesce in its continuance would imply callous indifference to suffering and mortality'.[23] His criticisms were wide-ranging. The buildings had 'the air of a prison that is neglected and dilapidated'[24] despite the fact that they had only been built in 1926. They had been erected as an exact replica of the older hospital that they replaced, and the only reasoning behind this was to move the institution out of the capital city Colombo. The hospital was dangerously overcrowded, so that 3000 patients were packed into buildings designed for only 1830. This was thought to be behind the high death rates at the institution, largely accounted for by tuberculosis and dysentery. In 1936 this had been 137 per thousand inmates, almost

double the average in India. Verandahs had been converted into bed-space, and patients slept on mats; by day they crouched there 'immobile and unoccupied in two long rows containing 45 apiece'.[25] The solitary confinement cells were condemned as 'unfit for human habitation'.[26] Only the female side came in for any praise, thanks to the efforts of Miss Robinson the Matron, but even here Mapother observed that there was no real attempt at treatment, 'the sight of nearly 1000 women sitting in orderly squares on the ground doing nothing or giggling without reason, hardly represents an ideal state of affairs'.[27]

It was not just the hospital itself that came in for his scrutiny. Mapother argued that there was no reason to suspect that there were differences in incidence in mental disorder and mental defect between Asian and Western societies. As such there was no excuse for the low ratio of psychiatric accommodation to the local population. He pointed out that in London there was a bed in a public mental hospital for one in every 200 of the capital's inhabitants, while in Ceylon this figure was about one for every 3000 (a total of 1830 beds for all 5.4 million of the island's inhabitants). Expenditure was similarly critiqued, Mapother concluding that in London spending on mental health facilities was about 25 per cent of that on hospitals for physical ailments while in Ceylon it was only 4 per cent. This demonstrated to the author that 'those in authority in the East have not yet reached a modern standpoint with regard to the relative importance of mental disorder and its treatment'.[28]

The outcome of this low expenditure was not simply overcrowding. The provision for patients was poor quality, largely because allowances per patient were almost half that of the average in India. The number of doctors at Angoda had not been increased to take account of the large patient population, with the effect that the doctor to patient ration was one-fifth of that allowed in India. The scene painted by Mapother of his arrival at the hospital suggests that the outcome of this was very little treatment for the inmates at all:

> The garden was densely packed with a turbulent mob of men a few of them entirely nude, the majority naked except for a loin cloth. Many were shouting remarks at the sky and waving their arms, while others shrieked insults above the din and shook their fists in each others faces. Now and then when actual violence seemed imminent a couple of male attendants would dart into the thick of the mob and extricate one of those quarrelling by dragging on one arm. Their manner of handling patients in the presence of the Medical Superintendent and myself was not reassuring as to what might happen in our absence.[29]

His prescription for improvement was far-reaching, and was composed of 13 recommendations which tackled the provision of psychiatry in Ceylon root and branch. In the first place legal reform was necessary. The historical origins of the Lunacy Ordinance of Ceylon were obscure, but it seemed to hark back to an age when mental illness was a legal rather than a medical matter. The individual had to be presented to a judicial authority, who would make the decision as to whether a doctor should be consulted or not. Once the doctor had been consulted, the judicial authority could order detention in the asylum; only the magistrate responsible for this order could authorise the subsequent release of the patient. The regulations seemed to be concerned mainly with those dangerous to others and with those who might be falsely presented as insane as part of a plot, and Mapother noted that 'the law does not seem to have contemplated treatment as a contingency to be considered'.[30] He suggested that new legislation be modelled on the English Mental Deficiency and Mental Treatment Acts, and that certification should be the last resort in a system where the emphasis was on voluntary patients seeking legally authorised therapy. As a separate note, he urged the authorities to devise new regulations for dealing with mothers who had killed their recently born child. He argued that these should not be tried as murderers, but rather should be admitted to psychiatric hospitals for treatment as civil rather than as criminal cases.[31]

He then tackled the institutional aspect of the system. He clearly felt that the reliance on one institution for the whole island resulted in the muddling together of different types of patient. In the first place he suggested that those admitted to the facilities through the penal system ought to be separated out. The custody of those awaiting trial for, or serving sentences for, serious crimes consisted of measures which Mapother felt were quite unsuitable in an environment where civil patients were under treatment and as such he thought a separate hospital needed to be built. He then suggested that the existing hospital at Angoda could be adapted to house what he called the 'chronic insane'. This involved measures such as pulling down its forbidding walls, painting the wards and other buildings, replacing bars on windows with 'armour plate glass', using impermeable flooring in the lavatories and building a new recreation hall. Mapother devoted much detail to the latter:

> This hall could be used daily for drill and gymnastic classes, it should be furnished with newspapers and books, with indoor games, and a gramophone and wireless set . . . here there should be given occasional concerts either organized by the staff of the institution, or provided

> by companies from outside if sympathizers could be found to do this. Display of sound films is usual nowadays in English mental hospitals and at some in India.[32]

He was similarly enthusiastic about 'outdoor games such as cricket and tennis and football', picnics and 'carefully supervised occupation' in the new regime he proposed.

With Angoda rescued, Mapother turned his attention to a range of new institutions. The first was a neuro-psychiatric clinic, to treat 'neurological cases of the clearly organic type' such as schizophrenia and 'general paralysis'.[33] Patients would only be admitted there on a voluntary basis, and it would have 100 beds for inpatients and would offer an outpatient service. Complementing this was the Psychopathic Hospital, with a capacity of 1500 beds. This would deal with patients likely to recover within 2 years, who would benefit from being separated from the chronic cases at Angoda but who were not suffering from conditions likely to respond to the treatments on offer at the Neurological Hospital. The regime would be similar to that at Angoda, consisting of recreation halls and occupational therapy opportunities.[34] Then there would be an Observation Home, to deal with those who may well be perfectly sane but who were at the time plunged into Angoda regardless of condition. This was essentially a clearing house, in which those in recent contact with the psychiatric system could be assessed and then directed to the correct institution from the number above once it was clearly established that they were suffering from mental illness. This would contain 300 beds, and patients were to remain there a maximum of 6 weeks, by which time a decision could be made about their ailments. He concluded his plans for this set of hospitals by pointing out that 'in order to cope with the future number of unavoidable cases plans will probably have to be made for another Mental Hospital'.[35]

While Mapother concerned himself with the institutional system, he did not neglect the issue of who would run it. He proposed that existing staff be sent to India to observe best practice there at Bangalore, Madras and Ranchi. He then suggested a 'special service of medical officers devoting themselves to psychiatry as a career'. He observed that only two of the five medical officers currently serving at Angoda had any sort of psychiatric training, and was sure that the hospital was seriously understaffed when compared with India where the ratio of patients to staff was between 5–1 and 9–1, whereas in Ceylon it was 16–1. He anticipated a system with 21 doctors in it at various levels of seniority and argued that 'the necessity to create a permanent and separate service of psychiatrists

must involve the provision of a career with such a rate of pay and chance of promotion as will render this specialty attractive to the suitable type of man'.[36] Alongside these doctors Mapother saw the need for 'a service of well trained mental nurses' arguing that at present 'there prevails a complete ignorance of the standards customary in modern institutions for the care of the insane'.[37] European nurses were to be sent out to Ceylon to supervise the hospitals and the training of local staff and the best of the latter were to be sent to England for specialist training that would qualify them to return to take up senior positions. Furthermore, he advocated the recruitment of 'young women of suitable education' to be trained as social workers to work with the local community to learn more about the circumstances of particular patients and to provide a means of 'aftercare' for those released from hospital. He was also keen to provide 'occupational therapists' trained to the standards that he had seen in India at Ranchi. Finally he urged the addition of psychiatry to the syllabus of medical students on the island, so that even those who did not go on to become psychiatrists 'would profit by an elementary knowledge of normal and morbid psychiatry', emphasising that 'the relation of psychiatry to neurology should be persistently stressed'.[38] Ceylon was not simply to have a new cadre of specialist doctors and nurses running its mental hospitals, it was to have a network of amateur psychiatrists spread throughout its clinics and general practices.

The plan was grand and the response at first seemed vigorous. His report was submitted to the Government on 9 May 1938 and by August 25 the Executive Committee of Health met to approve a strategy. All of the suggestions that were cheap were approved. The law was to be modernised, the syllabus at the Medical College was to be altered to incorporate instruction on 'special treatment of mentally defectives', senior staff were to be sent abroad to 'familiarize themselves with recent practice' and new staff were to be specially trained. However, there were no clear or definite instructions on the numbers of new staff to be recruited and the vague statement that 'the principle of the creation of a special service of Medical Officers devoting themselves to psychiatry as a career should be accepted' suggests that the Government was in no rush to commit itself to rapid expansion in the number of specialists. Indeed, when it came to giving effect to Mapother's plans for a new institutional network, there was a considerable downsizing of scale; a neuro-psychiatric clinic at the General Hospital to be staffed by a specially qualified medical officer was provided, along with a Psychopathic Hospital at Maharagama for 300 patients with a House of Observation for 100 patients attached, and a separate Institution for housing

inmates who were committed to detention at an Asylum by order of the courts at Angoda, which was to have 300 inmates.[39]

Mapother had wanted his neuro-psychiatric clinic to have five 'specially qualified medical officers', his Psychopathic Hospital to have 1500 beds and the House of Observation to have 300 beds. The Government made it explicit that 'it is, however, realized that all his proposals cannot be undertaken immediately on account of the heavy cost involved in carrying them out'. Tellingly, there is no mention of giving effect to another of Mapother's proposals. He had suggested the 'establishment of a Visiting Committee for each institution' to 'meet at the hospital, carry out inspections, and make recommendations'.[40] It would appear that the Government of Ceylon had learned its lesson; allowing visitors into its asylums and inviting them to report back could be a costly and troublesome business. Indeed, when news of the Government's alteration of his scheme filtered back, Mapother was furious. He wrote to John Pye at the European Association as follows:

> I have been rather disturbed by the indications in the newspapers that the fulfilment of my recommendations was likely to be distorted. I had thought of bringing the whole matter to the notice of the Secretary of State. However, the international crisis intervened and made the raising of all minor questions inopportune. The crisis will presumably have subsided shortly and if it appears that the programme proposed diverges entirely from my recommendations it may seem advisable that I should ask the Sec of State to interest himself in the matter. I think this would be better than that I should deal with the situation by a comment on inadequate proposals in the Ceylon newspapers.[41]

There seems to have been no approach to the Secretary of State, and no recourse to the newspapers. Mapother was dead within 18 months of writing the above letter, and the collection of his correspondence reveals that his interest in south Asia in that time was limited to trying to persuade the Rockefeller Foundation to fund fellowships for Indian students to study at the Maudesly.[42] Indeed, the international crisis that he mentioned was the prelude to the Munich agreement of 1938 between Chamberlain and Hitler, and of course it did not subside but escalated into the Second World War, which was followed by rapid decolonisation by the British in south Asia. Mapother's grand plans for psychiatry in Sri Lanka were never realised.

## Mapother in India

'It would be difficult for the most jingoistic to affirm that, in the matter of provision for mental disorder in India, the British "bearing of the white man's burden" has been quite adequate.' The opening declaration of Mapother's report on his travels in India accurately set the tone of what was to follow, and he made sure that readers did not miss the point by emphasising that the state of affairs there 'sets an awkward task for the holders of the moderate view (that) British rule has been a benefit'.[43] The report was severely critical of the facilities, noted the demoralisation of many of the staff, and was gloomy about the scale of the problem and the difficulties of undertaking any attempt at improvement.

Mapother had worked hard to arrive at his conclusion, as he took full advantage of the freedom given to him by the India Office:

> I had a conversation of nearly an hour with Sir John Megaw. He was quite alive to the deficiencies of psychiatric arrangements in India, but convinced that other needs must have priority and that economic reasons forbade these defect being rectified. He arranged that I should have every possible facility to meet those whom I wished to see in India, and to visit all institutions.[44]

As noted earlier, he made visits to hospitals as far apart as Bombay, Madras, Lahore and Ranchi, in all seeing for himself seven of India's psychiatric units. He also attended the Indian Science Congress at Calcutta and interviewed a number of officers in the colonial medical service, including the Director-General of the IMS himself. He compiled a 'Who's Who in relation to psychiatry in India' in his report that recorded his observations on those he had met. Of the Surgeon-Generals of Bengal and Madras he recorded that they were 'extremely friendly and expressed appreciation of the situation coupled as usual with an almost excessive clarity of vision as to the difficulties'.[45] Of Berkeley Hill, who had served as Superintendent of the Ranchi Hospital, he wrote that he 'is by far the ablest man that there has been in psychiatry [but] he is a bitter controversialist with a dangerous wit who scored so successfully off his official superiors that they retired him as soon as possible'.[46] He was equally critical of the Indians that he encountered. Of Lt. Col. L.E. Dunjibhoy in Calcutta he observed that 'his annual reports include reference to his wide travels and the closeness of his acquaintance with psychiatrists in Europe and America. But he did not seem to have equal intimacy with psychiatry itself.'[47] In Bombay he

noted 'the young man in charge of the psychiatric out-patient clinic is a young Parsee whose name I have mislaid. He is a psychotherapist trained at the Tavistock Clinic with an ingenious and credulous mind and little knowledge of solid psychiatry.'[48] He explained that Dr G. Bose in Calcutta was 'devoted to psychoanalysis' and as such was 'a danger to psychiatry in India'.[49]

Some did not come in for such strong judgement, so that 'Dr Banarsi Das was trained at the Maudsley . . . his hospital is deplorable but it is probably not his fault'.[50] Lt. Col. Lodge Patch of the facility in Lahore was described as 'with intelligence and keenness nearly equal to that of Berkeley Hill, he unites stability and balance'[51] and Venkata Subba Rao at Madras had 'a real knowledge of psychiatry and its needs [and] an unselfish enthusiasm'. It was in them that Mapother saw some cause for optimism, and of the latter he noted that 'he seemed to me the best Indian in British India to support if the Rockefeller Foundation were disposed to foster psychiatry there in any way'.[52]

Having traveled widely and assessed the key men, his overall judgements were damning. The asylums of India were 'a permanent monument of brutal stupidity and of a refusal to look at the rest of the world with any hope of learning from it', and he spoke readily of 'the wretched provision for the insane in India'.[53] The buildings were shaped by 'the conception held by the Public Works Department as to the nature of lunatics and the accommodation proper for them, unchecked by any such experience as could be borrowed from a psychiatrist', and he described 'one single ward in which I saw a female patient [that] was an exact replica of the accommodation for tigers at the Regents Park Zoo'.[54] The availability of services in British India was compared to that in the London County. There were 10 institutions there with 22,000 beds serving a population of 4.4 million, as compared to 19 institutions, and 9608 beds in the whole of British India for 276 million people. In London, there was a psychiatric bed for every 200 individuals, while in India there was one bed for 30,000. He identified wide divergences in provision within India; in Bombay Presidency there was one bed for every 12,000 of the population, as compared with Bengal, Bihar and Orissa where there was only one bed for every 57,000 individuals. While there were five psychiatric beds for every eight beds for 'physical disease' in London, there was only one bed for psychiatry to every seven for bodily ailments in India. Thus, even allowing for difference in economics and poverty, it was obvious that the shortage of beds for mental capacity was four times that in the UK. The London City Council spent £2.2 million per annum on the mental health services

(25 per cent of the total health budget), while all the mental hospitals of India accounted for just Rs. 3.6 million (£0.25 million), or less than 10 per cent of the total medical spending.[55]

This shortage of provision partly explained the problem that he identified of overcrowding, which in turn emphasised the lack of staff. He noted that where there was no overcrowding, as in Bengal, this was a result of ‘a deliberate refusal to fill institutions beyond capacity’.[56] The situation in Bombay was the worst, and he drew out the consequences of overcrowding; the confinement of both civil and criminal lunatics in the same institutions, the inability to separate out the chronic from the acute patients, an official disinclination to admit cases in the early stages of illness who might most benefit from treatment, and the rapid discharge of those who while not cured, had moderated their behaviour. The outcome of all this was ‘the growth of a well founded tradition that the asylum is a place fit only for the segregation of such dregs, and that it is inhuman to send or keep there any persons who are not either indifferent or anti-social’.[57]

Indeed, what provision was available was then analysed in terms of cost. Mapother discovered that there were enormous disparities within India on what was spent per patient; in Lahore this was as much as Rs. 553 per patient while in Agra it was less than half that as Rs. 264. The direct result of this was that ‘the death rate of the mental hospitals is in proportion to their cheapness’,[58] so that at Ranchi where Rs. 116 was spent on diet, the hospital death rate was about the same as the death rate in the community around it, at about 25/1000 per annum. At Agra, where only Rs. 63 was spent on food, the death rate in the hospital was almost five times greater than that in the local population. The report made the obvious conclusion that ‘it is futile to expect that any material improvement in the arrangements for dealing with mental disorder in India can be made without a very large increase in cost’.[59]

Blame for the problems lay in the lack of leadership shown in the matter of medicine in India according to Mapother. The British officers of the IMS were settled into what Mapother called ‘a long tradition that anything but passive acceptance was grousing, and that the way to acquire merit was to avoid grousing’.[60] Indeed, this had been exacerbated in the 1930s by the peculiarities of the period, and Mapother thought that ‘the higher officers of the IMS strike one as having a sense that their whole Service is under notice to quit’, a reference to the Nationalist campaigns of the 1930s against the British and to the Indianisation of medical provision in India that had been gathering pace since the end of

the First World War.[61] Mapother therefore argued that 'the whole situation in India cries aloud for a crusade',[62] and saw the leaders in this to be both Indians and Americans. The Indians could draw on the example of the independent state of Mysore. Mapother had visited the mental hospital there and called it 'a monument to the vision and wisdom of all those responsible for the mental defectives in the East. The Institution is almost unique among mental Hospitals in India . . . it is quite evident that modern methods of diagnosis and treatment are available and freely used.'[63] Though established in the 1840s when Mysore was ruled by the British, the hospital had been extensively and recently improved. A new building, well-maintained grounds and laboratory facilities had been provided in the 1920s by the local Maharajah whose family had ruled Mysore as a state independent of British India since 1881. It had been modeled on the Maudesly by its first Superintendent, Frank Noronha, an Indian doctor who had studied psychiatry in London.

As for the Americans, Mapother was hopeful that 'the Rockefeller Foundation could even by the loan of its name and at very little cost give to such a crusade the influence which no private person could exert'.[64] As already stated, Mapother had a longstanding relationship with the Foundation, and he took it upon himself to raise the issue of India with its representatives. He closed a letter to his contact with a paragraph that read 'some day I hope your Foundation will take a serious interest in psychiatric arrangements for four hundred million people in India. At present they are primitive but I believe the situation is such that great development is possible.'[65] In other correspondence he noted that:

> I told the Rockefeller people that . . . it would be an excellent plan if they could see their way towards helping with the finance in India of a psychiatric clinic at which Indians could get the sort of education in their own country that would enable them to deal with early and minor cases.[66]

However, it does not seem as if he managed to spark interest in the crusade that he wanted to inspire; 'I had rather hoped for a beginning of at least a few fellowships in India, but this and many other hopeful ideas must now be infinitely postponed' was the position of his correspondent at the Foundation by the end of 1939.[67]

The shape that the crusade was to have taken was based on the same principles as that he proposed in Ceylon. He advocated changes in the

law relating to civil cases so that the power to admit to psychiatric hospitals lay with patients and doctors rather than magistrates, and a beefed up Visiting Committee needed to be appointed to each institution. All medical students were to receive an elementary education in psychiatry, specialist colleges in north and south India were to be established for the training of psychiatrists, finance was to be made available to send the best abroad to study recent developments, and a cadre of mental health nurses and social workers was to be nurtured. In a note on the syllabus to be studied by this new generation he added 'emphasise need for education of medical students in neuropsychiatry'.[68] To pursue these reforms and to oversee their operation a psychiatrist should be appointed to the Public Health Commission for the Government of India. Finally, a programme of survey and public information was to be devised, so that the problems of mental illness in India could be studied and the benefits of early treatment at the hospitals could be conveyed to local communities.[69] Any attempt to dispute this scheme on grounds of cost was dismissed in advance in the opening paragraphs of his introduction, in which Mapother pointed to the grand project of the time in which the British were erecting an imperial capital at New Delhi. He wryly noted that 'it serves only for the work and ceremonial entertainment of the representatives of the British Raj, its more fortunate officials, and the native Princes who support it', before reminding readers that it had cost £18 million to date.

It is unclear that anyone ever saw this plan or read his recommendations. Mapother wrote in July of 1938 that 'I am hoping shortly to get together a note of my impressions on the situation in India',[70] so it is clear that he did not get round to writing his notes within a year of his visit. In his notes he laid-out a plan for the report he was to write and included a list of those to be contacted about it which included Sir John Megaw, the Director-General of the Indian Medical Service, and the Viceroy himself. There is no evidence that they received the report as no copy remains in the India Office collection at the British Library. Indeed, it is not clear what they would have done with it had it ended up in their offices, because Mapother had committed himself to the deal that gave him access to India but which meant that 'the information which I obtained was not for publication'. He had visited India, and been appalled by what he saw of the psychiatric services of the colonial administration there, but it was that very administration that prevented him from doing anything about the state of affairs that he had found.

## Conclusion

The tale of Mapother's travels in south Asia can be interpreted in different ways. A cursory reading of the evidence brings to mind the post-colonial critiques of medicine in colonial contexts mentioned earlier. It might be argued that Mapother was simply seeking to re-establish an Orientalist colonial order in recommending greater engagement between psychiatric institutions in south Asia and the wider world. After all, this was a period in which psychiatry was increasingly 'Indianised', and his appearance as a British expert who gave full voice to harsh criticism could be read as an act of colonial paternalism; the superiority of the European was being asserted over the incomplete or childlike efforts of the Asian.[71] Indeed, the idea that Indian doctors needed to be sent to London for training seems to emphasise the colonial relationship, in which those on the imperial periphery are directed to the metropole to be civilised.[72] Such a reading would be ahistorical and overly determined by theory. In reality, Mapother was as critical of the British and European individuals that he encountered on his travels as he was of Indians, and commended as few of the former as he did of the latter. He used imperial rhetoric only where it could be employed against British colonial administrators in order to shame them into greater action, not in order to subject Asians. The sole hospital in south Asia that he lauded was that established and run entirely by Indians in the independent state of Mysore. He did not recommend training in London per se, but at the Maudesly, the hospital that was his life's work and which he regarded as a model for psychiatric training, treatment and administration in general. Indeed, the blueprint that he exported to south Asia drew heavily on the one that he had already imposed on London, and which he clearly considered to be the solution to the problems of social psychiatry the world over. If he was empire-building it was for his institution and his ideas, not his nation.[73]

Indeed, Mapother's observations demonstrate just how far the British had failed in using psychiatry as a tool of empire. The picture he presents rather undermines the lofty rhetoric of imperial medicine in the region, which had boasted of its benefits to the subject populations since the nineteenth century; 'the establishment of lunatic asylums is indeed a noble work of charity, and will confer greater honor on the names of our Indian rulers than the achievement of their proudest victories'.[74] Coming towards the end of British rule in south Asia, Mapother provides a clear sense that when viewed from outside of the region and its

corridors of power, the mental health services of the imperial regime conferred little honour on the colonisers.

## Notes

1. This summary of his career is based on A. Lewis, 'Edward Mapother and the Making of the Maudsley Hospital', *British Journal of Psychiatry*, 115, 529 (December 1969) 1349–66.
2. To The Rockefeller Foundation, March 1931.
3. M. Jones, *Health Policy in Britain's Model Colony: Ceylon 1900–1948* (Hyderabad: 2004), p. 76.
4. PRO CO 54/950/4 From S.T. Gunesekara to E. Mapother 21 July 1937.
5. Jones, p. 262.
6. See Rhodri Hayward, 'Mapother, Edward (1881–1940)', *Oxford Dictionary of National Biography* (Oxford: 2004) [http://www.oxforddnb.com/view/article/58394, accessed 5 April 2006].
7. Annual Report on the Lunatic Asylums in the Punjab for the Year 1879, p. 3.
8. Minute by President Madras 29 October 1865 GOI (Public) Procs, 27 February 1869, 105–7A.
9. For more on the nineteenth-century see J. Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857–1900* (Basingstoke: 2000); W. Ernst, *Mad Tales from the Raj: The European Insane in British India 1800–1858* (London: 1991); S. Kapila, *The making of colonial psychiatry, Bombay Presidency, 1849–1940* (Unpublished Ph.D. thesis: University of London: 2002).
10. J. Mills, 'The History of Modern Psychiatry in India: 1795 to 1947', *History of Psychiatry*, 4 (2001).
11. C. Hartnack, *Psychoanalysis in Colonial India* (Oxford: 2001).
12. A phrase taken from Daniel Headrick's *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (Oxford: 1981).
13. R. MacLeod, 'Introduction', in R. MacLeod and M. Lewis, *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London: 1988), p. 2.
14. E. Mapother, 'Report on Present Arrangements for the Treatment of Mental Disorders in Ceylon and Suggestions for Reorganization', in Papers laid before the State Council of Ceylon during the year 1938 (Government of Ceylon Press, Colombo; 1939). Available at British Library, C.S.B. 24/3. Hereafter Ceylon Report.
15. Ibid., p. 3.
16. Royal Bethlem Hospital Archive. EM-01 Papers of Edward Mapother, Treatment of Mental Disorders in Ceylon file. To Dr O'Brien, 26 February 1937. Hereafter Ceylon File.
17. Ceylon File. From John Pye, 23 September 1938.
18. In 1931 Ceylon had been granted some limited self-government, but senior officials such as the Governor remained British and the Colonial Office in London remained the distant source of authority. The Colonial Office and the Medical Advisor Dr Stanton had opposed the appointment of Gunasekara as the first local Medical Director in October 1936. See Jones, p. 76.

19. L. Smith, '"The Keeper Must Himself be Kept": Visitation and the Lunatic Asylum in England, 1750–1850', in G. Mooney and J. Reinarz (eds), *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Amsterdam: Clio Medica/The Wellcome Series in the History of Medicine, Forthcoming).
20. Ceylon Report, p. 3.
21. EM-01 Report on psychiatry in India file, p. 33. Hereafter India file.
22. India File. 'Growing Interest in Psychiatry, Dr Mapother Interviewed, Visit to Madras' (undated newspaper clipping).
23. Ceylon Report, p. 3.
24. Ibid., p. 6.
25. Ibid., p. 7.
26. Ibid., p. 8.
27. Ibid.
28. Ibid., p. 4.
29. Ibid., p. 7.
30. Ibid., p. 12.
31. Ibid., p. 9.
32. Ibid., p. 11.
33. Ibid., p. 17.
34. Ibid., p. 20.
35. Ibid., p. 21.
36. Ibid., p. 23.
37. Ibid., p. 25.
38. Ibid., p. 27.
39. Ibid., p. 28.
40. Ibid., p. 16.
41. Ceylon file. To John Pye 4 October 1938.
42. India file. To Dr O'Brien, The Rockefeller Foundation, New York, 8 July 1938.
43. India file. Report on psychiatry in India, 1. Hereafter India report.
44. India Report, p. 33.
45. Ibid., p. 34.
46. Ibid., p. 37.
47. Ibid.
48. Ibid., p. 38.
49. Ibid., p. 37.
50. Ibid.
51. Ibid., p. 38.
52. Ibid., p. 39.
53. Ibid., p. 1.
54. Ibid., p. 31.
55. Ibid., pp. 3–4.
56. Ibid., p. 5.
57. Ibid.
58. Ibid., p. 9.
59. Ibid.
60. Ibid., p. 10.
61. For more on this process see M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859–1914* (Cambridge: 1994), p. 233; J. Mills, 'The History of Modern Psychiatry in India, 1858–1947', *History of Psychiatry*, 4 (2001) 449–51.

62. India Report, p. 10.
63. Sir Mirza Ismail, *My Public Life: Recollections and Reminiscences* (London: 1950).
64. India Report, p. 10.
65. India File. To Dr O'Brien, The Rockefeller Foundation, 8 July 1938.
66. India File. To Lt Cnl Owen Berkeley Hill, Ranchi, 23 February 1937.
67. India File. From Alan Gregg, The Rockefeller Foundation, 3 December 1939.
68. India Report, p. 1.
69. Ibid., pp. 18–26.
70. India File. To Dr O'Brien, The Rockefeller Foundation, 8 July 1938.
71. Orientalism is an analytical device that draws heavily on the work of Edward Said, particularly *Orientalism* (New York: 1978) and *Culture and Imperialism* (London: 1993). Ashis Nandy mapped the paternalistic ideology of British imperialism in south Asia in *The Intimate Enemy: Loss and Recovery of Self under Colonialism* (New Delhi: 1983).
72. For recent discussions of this relationship see H. Fischer-Tiné and Michael Mann (eds), *Colonialism as Civilizing Mission: Cultural Ideology in British India* (London: 2004).
73. This view seems to be corroborated by Mapother's DNB entry, which emphasises that 'he never abandoned his commitment to the Maudsley [which] provided the institutional space and intellectual opportunity for Mapother to realize his own vision of psychiatry' [http://www.oxforddnb.com/view/article/58394, accessed 5 April 2006].
74. Forbes Winslow, 'Review of Practical Remarks on Insanity in India', *Psychological Medicine and Mental Pathology*, 6 (1853) 356–67.

# 8

# The Nature of the Native Mind: Contested Views of Dutch Colonial Psychiatrists in the former Dutch East Indies

*Hans Pols*

> I made a special study of the STOVIA (the medical school for the natives). After all, most of those promoting the awakening of Asia were doctors, and not lawyers as was the case in Europe. Perhaps the movements for enlightenment in Europe were motivated by the violation of people's sense of justice. In Asia the awakening was inflamed by the awareness that society was sick and must be cured.
>
> Pramoedya Ananta Toer, *House of Glass*
> [Vol. 4 or the *Buru Quartet*], 1988.[1]

In the middle of December 1923, during the wet season in the former Dutch East Indies, members of the notorious pro-business and reactionary *Politiek-Economischen Bond* [PEB; Political-Economical Union], held a meeting in Surabaya. The Union advocated free competition, the maintenance of law and order by abrogating the political rights of Indonesians, and reducing spending on educational facilities open to them. The invited speaker of that meeting was not a politician but a psychiatrist, Dr Travaglino. He had spent 9 years in the Dutch East Indies as the medical superintendent of the mental hospital near Lawang, about 20 kilometres to the south. It might appear unusual that a psychiatrist would address a meeting of a political party representing plantation owners and the sugar syndicate, although it should be noted that, in his speech, he addressed the importance of a scientific understanding of the native mind to rule colonial society justly and effectively. In fact, psychiatrists in the Dutch East Indies regularly addressed meetings and published their ideas in popular magazines and newspapers. In the

former Dutch East Indies, psychological discourse on the nature of the native mind was rather common-place.

During the first two decades of the twentieth century, Dutch colonial administration was imbued by the ideas of the ethical policy, which sought to increase the welfare of the indigenous population by improving economic conditions, by building a viable infrastructure and irrigation works, and by providing health care, educational opportunities, and modest credit facilities.[2] The colonial government followed a policy of association with the Indonesian aristocracy and leading intellectuals, and encouraged the formation of indigenous social, cultural, and political movements. One of the high points of the ethical policy was the establishment of the *Volksraad* [popular assembly], the parliament of the Dutch East Indies, in May 1918. After 1920, the Dutch colonial government abandoned the principles of the ethical policy because of concerns about the increasingly vocal nationalist movement. In 1922 and 1923, a number of strikes were ruthlessly repressed, thousands of workers fired, and nationalist leaders exiled. The freedom of assembly and the freedom of the press were significantly reduced. The reactionary climate of the 1920s is best illustrated by the rise of the *Politiek-Economischen Bond*, which was founded in 1919, and represented in the *Volksraad* by the Surabaya lawyer Arnold van Gennep. The government also instituted measures to reduce spending, which led to a reduction of the number of positions available to educated indigenous individuals and the wages they could expected to earn, and fewer educational opportunities.[3] By 1923, few Indonesians trusted that the colonial government took their interests into account. At that time, most Indonesian nationalists advocated a policy of non-cooperation.

In the 1920s, discussions about the nature of the indigenous mind were presented as arguments for repressive political measures by members and sympathisers of the PEB.[4] Indonesian intellectuals and participants in the nationalist movements, aware of the political significance of these views, protested against them, disputed interpretations and evidence, and articulated alternative views. In this chapter, I focus on the views advocated by Dutch psychiatrists, the political context in which they gained significance, and the explicit and outspoken reactions against them by representatives of the Indonesian nationalist movements. Many of these representatives were physicians who had studied at the indigenous medical school (STOVIA, School ter Opleiding van Indische Artsen [School for the Education of Indies Physicians]) in Batavia [Jakarta].[5] In the Dutch East Indies, physicians

and medical students became active in a wide variety of nationalist movements. In their critique of these psychiatric views, they displayed both a thorough awareness of the political role of this seemingly scientific discourse as well as of the medical, psychiatric, and psychological literature. They provided a plethora of arguments to counteract these views, providing a coherent critique of psychiatry as a colonial ideology.

## Politics and psychology

Petrus Henri Marie Travaglino had moved to the Dutch East Indies after holding various positions in psychiatric institutions in the Netherlands, primarily to study the primitive psyche.[6] He was the medical superintendent of the mental hospital near Lawang, where he had ample opportunity to observe mental illness in the indigenous population of Java. In his talk on politics and psychology, he spent relatively little time discussing mental illness. Instead, he advocated the formulation of a psychological colonial policy on the basis of an extensive knowledge of the psyche of the Indonesian people. It was, after all, necessary to know the psyche of a people to govern effectively and justly.[7] Travaglino mentioned Prohibition in the United States and the outlawing of prostitution in Rotterdam as examples where this principle had not been followed. Unfortunately, too often, laws only reflected the desires and wishes of lawmakers, leading to ineffective measures. A father who likes to have a stiff drink every once in a while, knowing its beneficial mental and physical benefits, would not, on that basis, recommend one to his own children.[8] Lawmakers should, similarly, keep the needs and nature of their subjects in mind instead of operating from preconceived ideas or on the basis of wish-fulfilment.[9]

The speaker then presented some intriguing observations of his patients. During the last 9 years, he had observed psychoses induced by powerful emotional events, which were accompanied by the expression of highly charged emotions ('amok' was one of these). This type of psychosis occurred on Java seven to ten times more often than in Europe.[10] According to Travaglino, this indicated that indigenous individuals had an unusual sensitivity to emotions. By comparing the expressions of mental illness in different racial and ethnic groups, Travaglino followed the example of Emil Kraepelin, who had visited Java in 1904 to conduct research in comparative psychiatry. Kraepelin intended to investigate differences in incidence and manifestations of mental illness in different racial and ethnic groups, and

spent 3 weeks in the mental hospital near Buitenzorg [Bogor], investigating patients of indigenous, Chinese, and European background.[11] He concluded that the symptoms of dementia praecox were less severe in indigenous patients and that their prognosis was much better.[12] Kraepelin hoped that his observations would contribute to a *Völkerpsychologie* [comparative anthropological psychology], thereby contributing to a psychology of the psyche of the Indonesian people.[13]

Travaglino argued that emotional people tended to suffer from emotional psychoses. He presented a great amount of anecdotal evidence, among them the reactions of his indigenous personnel when he admonished them or administered punishments, the playfulness of children in the villages, the bamboo-stick fighting of the Madurese, the imaginative dancing of the Javanese when the gamelan is played, and the fantastic confabulations some indigenous individuals could come up with. European fairy tales only featured dragons with three or four heads while dragons in Eastern sagas had 100 or even 1000 heads and legs! According to Travaglino, emotionality and imagination were typical of childlike or infantile psyches. As with children, indigenous individuals were primarily guided by their primary processes (which involve instinct and emotion); their secondary processes (which involve planning and rationality) were present only in rudimentary form. Indigenous individuals were driven by strong vital functions and motivated by a strong desire for sensual enjoyment. They were highly egocentric and ruled by desire. Their sense of social responsibility was weakly developed. Sexual impulses were predominant. They could be completely absorbed by whatever caught their attention (such as music or the wayang) while ignoring everything else. Travaglino mentioned as example a group watching a parade whose attention he failed to get when he wanted to pass them by in his car. On another occasion nobody noticed him and his rather noisy hunting party when they passed by a group watching a wayang play. He concluded that indigenous individuals stood on a more primitive level of evolution.

Travaglino presented several implications for colonial administration. Because indigenous individuals have a rich imagination, are highly suggestible, and are predominantly guided by their emotions, they could be easily misled by radicals, who were like sparks flying around barrels of dynamite.[14] He advocated repressive measures to prevent this, including thorough control of the native press and jailing agitators. Travaglino continued advocating the teaching of trades and agricultural

practices over providing higher education and science teaching, which he considered premature. He ended his speech by advocating modesty and patience. Because of the limited capacities of the indigenous psyche, social change had to be slow and gradual. Naturally, colonial policy was aimed at the ultimate independence of Indonesia. To reach this end, the population had to be guided by a strong fatherly hand which would not hesitate to castigate its subjects when the circumstances required it.

Travaglino stated several times that Eastern culture was not inferior (or superior for that matter) but merely different. As an analogy he referred to the differences between men and women; they are different, but it would not be justified to declare that one was inferior to the other. He believed that it would display an unacceptable level of Western arrogance if one were to assume that the Indonesian people would ultimately reach the level of mental development currently attained in the West. It could very well be possible that these people were destined to a different form of civilisation. Whatever the ultimate end-point of the process of evolution in Eastern societies, colonial administrators needed to study and understand the characteristics of the native psyche, appreciate its different nature, and patiently guide its evolution to its ultimate destination. While it was not unusual that scientific arguments were used to justify colonial policy, it was unusual for psychology to take such a prominent role.[15]

Travaglino's views were not unknown in the Dutch East Indies. He had become a household name after Arnold van Gennep, representative of the *Politiek-Economischen Bond* in the Volksraad, had quoted him extensively in one of his most notorious speeches. In this speech, van Gennep argued that the indigenous population was not mature enough to exercise political rights, among them the right to vote.[16] He advocated curtailing the freedom of the press and the freedom of congregation, and supported the establishment of small desa councils where experience in the practice of democracy could be gained. He also emphasised the need for the moral education of the Indonesian population. To make matters worse, he proposed the establishment of a commission for the psychological and ethnological research of the indigenous population, in particular its morality, to place colonial policy on a sound scientific footing.[17] This would help the indigenous population to gain self-knowledge and further their moral education, which thus far had been wanting. When the indigenous members of the *Volksraad* protested, he used Travaglino's characterisation of the native psyche to qualify their reactions. At the time of Travaglino's speech, his sympathies with the PEB were public

knowledge. For leaders of the nationalist movement, critiquing his views became a mandate.

## The psyche of the Malay

About 2 months after Travaglino held his speech, on a Friday evening, another psychiatrist, Feico Herman van Loon, addressed a meeting of the renowned *Indisch Genootschap* [Indies Society] in the Hague, the Netherlands. The Indies Society was a meeting place of scientists, politicians, and leading citizens who endorsed the ethical policy. Its chairman was Professor Cornelis van Vollenhoven, a fervent advocate of the ethical policy and well-known investigator of the nature of *adat* or indigenous law in the Dutch East Indies.[18] Van Loon had spent about a decade on Java, the first few years as physician involved in the notorious pest eradication campaigns on Java, and subsequently as instructor at the STOVIA in neurology and psychiatry, and as director of the Batavia psychiatric clinic. The Dutch East Indies were a fascinating place for a psychiatrist: 'nowhere else in this world can we observe so many serious neurological disturbances as in the Dutch East Indies.'[19] Not only was the incidence of mental illness much higher in the colonies, the nature and manifestations of mental illness among the indigenous populations differed markedly from what was known in Europe. Apparently, normal, everyday life in the Indies bordered on the pathological; similarly, van Loon's characterisation of the normal indigenous mind, which reflected Travaglino's views in many respects, was close to being pathological itself. In the tropics, the distinctions between the normal and the pathological were unclear, while the latter threatened to engulf the former.[20]

Van Loon opened by stating that very little was known about the physiology and psychology of the indigenous population. This was unfortunate, because, in his opinion, 'only pure scientific research could save us out of the swamp in which, also in the Netherlands, the whole colonial question is about to sink.'[21] Collaboration between the races in the tropical zones could only be successful when it was based on mutual understanding, trust, love, and a willingness to cooperate. Naturally, an appreciation of the inherent differences between the Malay and the white races was essential to achieve this end. Such an appreciation did not imply an evaluation of either one being as being inferior, but only a recognition of the differences between them (van Loon used the man/woman metaphor as well). To bring further progress to the Dutch East Indies, knowledge of the

mental material to be dealt with was essential. Like Travaglino, Van Loon advocated a psychological colonial policy, based on knowledge of the nature of its subjects.[22] Van Loon's findings were based on his experiences in the Indies, a number of commonplace observations of everyday life, and several psychological experiments he had conducted on patients of the psychiatric clinic and students at the medical school.

Van Loon first commented on the slowness, the laziness, and the lack of activity and initiative of the Malay and claimed that anyone who had native servants could attest to this. He then discussed their poorly developed secondary functions involved in reasoning, planning, and foresight. Consequently, the Malay were not interested in the future at all but were completely consumed by present-day concerns. Their behaviour was characterised by a strong emotionality, impulsiveness, a complete lack of planning, and lack of concern for others, including their children. The Malay also took great delight in torturing animals. Unfortunately, they were highly suggestible and invariably reacted to impressions which evoked an emotional response. This could be illustrated with the ease manipulative individuals had in convincing the gullible population, who followed whatever they were told. The Malay did not think for themselves; a true herd mentality operated among them. Not surprisingly, superstition played a significant role as well. Sexual impulses were prominent in the daily life of the Malay.

Van Loon claimed that depression and melancholia were rare among his patients, while short-lasting strongly emotional psychoses or highly emotional acute states of confusion (among them latta and amok) were predominant.[23] On the basis of these observations, van Loon concluded that the psyche of the Malay was child-like. He stated that:

> Not only the strong primary and negligible secondary function and emotionality, but also the specific way in which affects are reacted to and the strong hyper-suggestibility are the main characteristics of the infantile psyche, as well as the tendency to imitate, a carefree nature, fantasy, impulsivity, desire for change, kindness next to cruelty, inclination to exaggerate and embellish, deceitfulness, fearfulness, etc.[24]

Van Loon argued that although the Malay have been remarkably successful in adopting Western customs and wisdom, this should not lead to premature conclusions with respect to their mental abilities. They were not able to conduct independent scientific research and needed to be

guided at all times. It was the obligation of the Dutch to provide this guidance.

## Reactions

The ideas and conclusions of Travaglino and van Loon were not original. Many Dutch individuals living in the East Indies (or Europeans living in colonies anywhere) shared these opinions and psychiatrists working in different colonial contexts expressed similar ideas, despite the differences in the populations they dealt with and the colonial contexts they lived in. Similar arguments had been presented by the physician J.H.F. Kohlbrugge, who in 1908 advocated a psychological colonial policy, which at that time only evoked a handful prickly scholarly responses.[25] What was unique in the case of Travaglino and van Loon were the extensive and outspoken reactions the opinions of both psychiatrists provoked among progressive Dutch groups in the Indies as well as from Indonesian physicians and nationalists. These protests were strong, persistent, articulate, and well-argued; they revealed a distinct political awareness of the ideological function of psychiatric and psychological discourse in a colonial context, the dependence of many of the observations of Travaglino and van Loon on the existence of a repressive colonial social structure, and the arbitrary nature of psychiatric diagnosis.

Many individuals involved in these protests were Indonesian physicians who had received their education at the STOVIA. In 1908, Budi Utomo, an organisation devoted to Javanese culture and creating educational opportunities for the Javanese, was founded on the instigation of the retired physician Wahidin Sudirohusodo by medical students on the premises of the STOVIA.[26] The Association of Indies Physicians, the forerunner of today's Indonesian Medical Association, was founded there in 1911.[27] During the 1910s and 1920s, the STOVIA was known as a hot-bed for Indonesian nationalism; medical students and physicians actively participated in the nationalist movements. After the turn of the twentieth century, a small number of Indonesian physicians went to the Netherlands for further study.[28] There, they became acquainted with radical political movements in the Netherlands, which inspired them to express their demands for independence. Indonesian students in the Netherlands, united in the *Indische Vereeniging* [Indies Association], expressed the most radical political views and took them back to Indonesia in the late 1920s, where they spearheaded the nationalist movement in the 1930s.[29]

## Initial reactions

Travaglino's speech led to a number of comments by Indonesian members of the PEB, which were published in a subsequent number of the magazine of the *Politiek-Economischen Bond*.[30] These friendly critics started out by praising Travaglino for his interest in the indigenous mind, the specific characteristics of which could possibly explain why, for example, Indonesians had hardly taken advantage of the hospital facilities that were available to them. But they also wondered whether it was possible to draw conclusions about the nature of the normal indigenous psyche merely on the basis of observations of the insane. They countered his observation that the Madurese were extremely cheerful and danced after winning the ox races by mentioning similar behaviour in Europeans when their team won a soccer match. About the incidents in which a group of Javanese failed to notice his car and the audience of a Wayang show had not paid any attention to his hunting party, they mentioned that Europeans could also be most inattentive at times. Such anecdotes therefore did not constitute evidence for typically Indonesian behaviour.

Travaglino's critics did not dismiss his proposal to gain a scientific understanding of the indigenous mind. They actually offered to collect observations and to set up experiments themselves. They asserted, however, that it was necessary to speak the language of the individuals one wished to investigate: 'The language is, after all, one of the best keys to the doors that give access to the psyche.'[31] Because they knew the languages of the different ethnic groups in the Indonesian archipelago, this would put them in an advantageous position. In addition, they stated that it was absolutely necessary for researchers to live among the population for a long time, at least several decades, to interpret behaviour properly. The results of this work might actually disprove Travaglino's suggestion that the natives would not be able to conduct independent scientific research.

Van Loon, addressing a highly educated and mostly Dutch audience, also received a number of critical comments. The first commentator bluntly stated that 'nobody currently present recognised the native as portrayed by the speaker.'[32] Although he was convinced that there were differences in the Eastern and Western mind, he chided van Loon for only emphasising the negative elements in the Eastern one. Several audience members related the many positive characteristics of Indonesians: their loyalty, friendliness, spiritual nature, endurance, continuous effort, and faithfulness. Enda Boemi, an Indonesian law student, stated that it was impossible to make generalisations that would apply to all of

the more than seventy different ethnic groups living in the Indies. He also argued that knowledge of the different indigenous languages and *adat* was necessary to interpret the behaviour of Indonesians, and that researchers had to live among them for long periods of time. Another audience member commented on the overly and rather disturbing sexual behaviours that could readily be observed at a Dutch farmers' market, which compared unfavourably to the behaviour of Indonesians, who were known to be modest and demure. Yet another audience member stated that observations made on the mentally ill could not possibly provide insight into the nature of normal individuals. In addition, he thought that it 'would be most interesting to have an Indonesian lecture on the psychological characteristics of the Dutch races.'[33]

The criticisms expressed by the indigenous press elaborated on those of the audiences of both talks. In the Surabaya-based *Kemadjoean Hindia* [Indies Progress], an author under the pseudonym of *Detonator* wondered whether Travaglino wanted to 'strengthen the reaction [the then-dominant reactionary political climate] by only emphasising the negative elements of the indigenous mind.' He conceded that the Javanese were currently weak, having lived as an unfree people for quite some time. However, when the Majapahit empire ruled, things were different: the Javanese were then known as a strong and enterprising race. The author concluded that freedom is an essential condition for developing character and strength.[34] In a later number, Dr Satiman, who was at that moment actively organising the Union of Intellectuals, criticised Travaglino for basing his conclusions on observations of the insane.[35] In the Communist *Sinar Hindia* [Indies Ray], a Bromo Tjorah [lit.: repeat offender], commented that Travaglino's speech must have delighted Europeans like Arnold van Gennep, then representative of the *Politiek-Eonomischen Bond* in the *Volksraad* [the popular assembly, the parliament of the Dutch East Indies to which most members were appointed by the Governor General and which only had an advisory function]. This author suspected that being a physician had not protected Travaglino from becoming narrow-minded in his opinions about 'a specific race, in particular when it is one to which he did not himself belong.'[36] He advised Travaglino to make the asylum near Lawang his permanent residence.

## Sustained critique

In early 1924, a satirical and biting account was published in the left-leaning journal *De Taak* [The Task] under the title 'Psychiatric Fascism.'[37]

In a parody, the author related how Travaglino had arrived at the meeting of the *Politiek-Economischen Bond* accompanied by his newly-wed wife, Weps (short, in Dutch, for Scientific European Psychology and Psychiatry), who was clearly appreciated by the audience because of her fresh and young looks. They had brought along their child prodigy, little Wisp, as well. She was childish, narrow-minded, and egocentric, but was not bothered by this because she had observed that all people at Lawang were like that. In addition, her father had told her that all Indonesian people shared these characteristics. These statements clearly delighted her as well as the audience. However, the author advised her spiritual father and guardian, the politician Arnold van Gennep, against taking Wisp to the meetings of the *Volksraad*, where she might be disappointed in the lack of childishness of its indigenous members, although she would delight in the narrow-mindedness of the representatives of the colonial government.

The body of 'Psychiatric Fascism' targeted Travaglino's statements. First of all, the author objected to making generalisations on the basis of a small number of observations made on insane individuals. As it was stated ironically, Travaglino had placed, 'on the basis of the characteristics of a rather small and partly abnormal group, more than fifty million people in the large cage of infantile people, although he placed a white notice next to it stating: *not inferior*.'[38] Second, he was criticised for making generalisations about a great number of ethnic groups in the Indies, which could not possibly hold true of all of them. It appeared that his wisdom was mostly based on his European books, which would preclude him from saying anything useful about the Indies. The author then concluded that the Dutch were markedly egocentric themselves: was not the whole colonial enterprise based on making money and the desire to enrich oneself? He believed that the lack of intelligence of the Javanese could be explained by referring to the lack of educational opportunities. Political protests (as well as the increasingly vocal nationalist movement) were due to increasing poverty, injustice, and inequity, rather than to the suggestibility of the population.

*De Taak* was a cultural weekly established by liberal and progressive Dutch professionals in Semarang in 1917.[39] It aimed to be an independent voice mediating the interests and demands of the different ethnic and political groups in the Indies. It was more radical than most adherents to the ethical policy because it supported the indigenous nationalist movements and advocated their participation in the political process. Its authors advocated municipal reform, political decentralisation, and equal representation; they investigated Javanese culture and

its history, and followed political developments in other colonies such as Mahatma Gandhi's non-cooperation movement in India. They maintained close ties with the more moderate representatives of the nationalist movements. Its editors were closely involved with the founding of the Java Institute in 1922, which aimed to study Javanese culture, its history, development, and current manifestations. The editors of *De Taak* were highly critical of the reactionary politics of the *Politiek-Economischen Bond* and explicitly related Travaglino's ideas to those of the *Bond*'s main representative in the *Volksraad*, Arnold van Gennep.

In the Netherlands, the Association for Indonesian Physicians (Netherlands Section) published a strongly worded and thoroughly argued pamphlet as a writ of defence against the lecture given by van Loon.[40] Although the pamphlet was issued anonymously, it is not difficult to ascertain who had participated in writing it. There were only a small number of Indonesian physicians studying in the Netherlands at the time, among them J.A. Latumeten, J.B. Sitanala, Sukiman Wirjosandjojo, J.J.D. Apituley, and P.L. Augustin.[41] Latumeten had been Travaglino's assistant and was at that moment finishing his dissertation in psychiatry. Most of these physicians were also members of the *Indonesische Vereeniging* [Indonesian Society; soon to be renamed *Perhimpunan Indonesia*], which had become one of the most radical political organisations advocating independence of Indonesia and the principle of non-cooperation. In the journal of that society, *Indonesia Merdeka* [Free Indonesia], four articles appeared criticising van Loon's speech.[42] The Association for Indies Physicians wrote to the Director of the Indies Civil Medical Service and the Governor General expressing their doubts about the suitability of van Loon teaching at the STOVIA and treating mentally ill patients.[43] The journal of the association also devoted several pages to the debate.[44]

The first objection made in these various writings dealt with the political motivations evident in van Loon's writings. Because he emphasised only the negative characteristics of the indigenous psyche (while mentioning only the positive ones of the Western mind), Van Loon appeared to belong to the right side of the spectrum; his speech was classified with other writings associated or sponsored by the *Politiek Economsichen Bond*. It was argued that, because van Loon's personality and political convictions shone through so clearly, his work could not be characterised as scientific; it was not guided by scientific neutrality and objectivity. The authors referred to the political situation in the Indies, which was characterised by an increasing polarisation between the Dutch and the Indonesians and increasingly repressive measures by

the colonial government. The colonial government was less and less able to hide the fact that the interests of both groups were diametrically opposed. In this context, it was politically expedient to portray Indonesians as emotional, child-like, unreliable, and in need of firm guidance: Van Loon had only argued, 'on scientific grounds, how and in which way the Western Older Brother and Leader could lead the nervous Malay child, which, according to him, was not able to walk the path of life on its own power, on that thorny road most safely.'[45]

A second objection referred to the inability of both psychiatrists to speak any of the local languages. Both had acquired rudimentary Malay, sufficient to deal with babus, kokkis, and servants, but not much more. Needless to say, they did not speak any of the local languages. Their interviews with patients had to be conducted with the aid of interpreters. The fine nuances in the utterances of the individuals interviewed surely would be lost. In addition, both psychiatrists had little knowledge of the *adat*, the customs, cultural conventions, and history of the people they were dealing with. This knowledge was critical in the correct interpretation of the indigenous mind.

A third objection referred to the prime data source of the research presented by Travaglino and van Loon, and the unnatural circumstances in which they had collected their findings. In their daily work, they encountered those few mentally ill Indonesians who had been institutionalised. Because there were very few mental hospitals in the former Dutch East Indies, only those mentally ill individuals who had become a public nuisance or who had been violent and a threat to the public order could be found there. Needless to say, these individuals were not representative of the population as whole. In addition, servants could not be used as a source of observations because they often came from the more undesirable classes.[46] The critics decried van Loon's observations of the students at the STOVIA, whom he saw twice a week for 1 hour only. The social distance between teachers and pupils at the local medical school was immense; van Loon surely did not belong to the small group of teachers who were trusted by the students.[47] The observations van Loon had made during the pest eradication campaigns were not representative of normal village people under normal circumstances, but made under duress and when dealing with government officials who had embarked on invasive and involuntary measures. Surely this did not provide the right context for the development of a 'genuine and loving interest in these child-like people'.[48]

Neither psychiatrist had acknowledged that their interactions with Indonesians were affected by the power differences between them,

which were inherent in the colonial situation. Centuries of colonial exploitation and repression had taught most indigenous individuals not to be forthcoming or to provide those answers they thought were desired.[49] The infantile nature of many Indonesians could much better be explained by the lack of education and high rates of illiteracy, which had persisted despite three centuries of Dutch presence and two decades of ethical policy! Instead of concluding that the natives stood, at present, at a more primitive evolutionary stage, the findings of both psychiatrists merely demonstrated the effects of lack of education, illiteracy, endemic disease and poor health, and the long-lasting effects of colonial domination. The research of both psychiatrists had only been descriptive; they had failed to give a convincing *explanation* of their findings, which surely had to refer to the political circumstances of the colonies.[50] The critics characterised the psychiatric theories on the nature of the indigenous psyche as the 'tragedy of an unfree people,' which only illustrated that one could, 'with impunity and without any consideration say *everything* ... about an unfree people.'[51]

The authors of these articles deconstructed the stark generalisations presented in the speeches of van Loon and Travaglino. According to the latest population census, there were more than 56 ethnic groups and over 500 languages within the Indonesian archipelago. It would be virtually impossible to find characteristics which were equally representative of the Javanese, the Menadonese, the Buginese, the Minangkabau, the Balinese, the Dayak, the Sundanese, the Amboinese, the Minahasa, and the many other ethnic groups. There were important religious and historical differences between these ethnic groups as well. To lump them all together as sharing the same Eastern, indigenous, Malay, or native mind would obliterate these differences and only provide baseless generalisations. The critics then proceeded to question the implicit assumptions on the nature of the Western mind, which appeared as an 'ideal psychic quantity, absolutely free of failings and unpleasant characteristics,' and to which the indigenous one was compared and found wanting.[52] The critics wondered whether the Western mind was best represented by the 'inhabitants of the Balkans, the Russians, the Scandinavians, the French, the Italians, etc. etc.?'[53] In case the Dutch were chosen, would the standard be 'the Freezian, the Hollander, or the Limburgher, or may be the tropical-Dutch?' Or did the authors have in mind the 'psyche of the Amsterdam street kid, the Rotterdam harbour worker, or the typical inhabitant of the Jordaan [a workers' neighbourhood in Amsterdam, a known hot-bed of political radicalism]?'[54] The Indonesian mind was far from uniform. Similarly, it was virtually

impossible to speak of a monolithic Western mind (characterised by rationality, forethought and planning, initiative, and science).

The critics then expressed doubts about whether the comparisons made by both psychiatrists were based on comparable groups of individuals.[55] Naturally, poor and uneducated Indonesian farmers would compare unfavourably to Dutch university graduates from good homes. When the Javanese were compared to the Arab and Chinese inhabitants of the Indies, it was overlooked that most individuals belonging to the last two ethnic groups were engaged in trade and finance. When Javanese individuals engaged in similar occupations were compared to them, the outcome would naturally be rather different. Similarly, when Dutch soldiers in the Royal Dutch Indies Army were compared to Amboinese ones, it was clear that the latter group excelled in courage and had the lowest delinquency rates. When Indonesians were given sufficient educational opportunities, it could be expected that their secondary functions would increase in strength. Only when their social, political, cultural, and historical conditions had become comparable could a valid comparison be made between the Indonesians and the Dutch.

The critics also undermined the Orientalist assumptions of both psychiatrists. According to Edward Said, Western individuals living in a colonial context tended to interpret the behaviour of themselves by referring to individual and idiosyncratic factors while interpreting the behaviour of the indigenous population by referring to essential underlying features shared by all Eastern individuals.[56] When both psychiatrists commented on the frequent physical movements and spontaneous dancing of the Menadonese, the critics argued that very similar behaviour could be observed on Dutch trade fairs, farmers markets, or during the carnival in the south of the Netherlands. There was no reason to assume that the Menadonese were expressing their essential nature while the Dutch farmers were merely responding to a special occasion. The critics also addressed the diagnosis of running amok, which was supposedly a frequent phenomenon in the colonies, revealing the highly charged emotional nature of the native. The critics were all too happy to supply a dozen Dutch newspaper clippings reporting fights involving weapons, knives, and blunt objects taking place on trade fairs, near bars, or within the home. As a matter of fact, the Great War could be characterised as European nations running amok, giving expression to the most base and aggressive impulses of human nature. The Dutch apparently interpreted the behaviour reported in those newspaper clippings in a radically different way depending on

whether it was that of a Dutch or an Indonesian person: 'Of course these are expressions of pathological souls, except with us they are acts of normal sweet boys.'[57]

The allegedly deceptive nature of the Indonesians was similarly countered by several newspaper clippings detailing fraud, graft, deceit, and deception committed by Dutch individuals. One critic even quoted a Dutch historical study describing colonial officials in the Dutch East Indies during the nineteenth century as 'lazy, unreliable, without commitment, engaged in theft, unqualified, [and] vain.'[58] The alleged delight Indonesians took in torturing animals was also countered by several newspaper clippings detailing similar behaviour in the Dutch. Since observations on behaviour collected on an anecdotal basis failed to reveal any inherent or pervasive differences between the Hollander and the Indonesian, the critics wondered upon which the self-assured conclusions of both psychiatrists were based.

Apparently following the suggestion of one of van Loon's critics that he would be most interested in hearing an Indonesian study on the nature of the Dutch mind, one critic decided to turn the tables. He provided a list of highly unfavourable characteristics of the Dutch psyche, including crude materialism (expressed in excessive thriftiness, lack of hospitality, egoism, and lack of philanthropy), lack of sensitivity (as evidenced in unfriendliness, lack of social skills, arrogance, despotism, presumptuousness), allegiance to Bacchus (characterised by lack of thriftiness and lack of attention to moral or social allegiances), unhygienic behaviour (as witnessed in the lack of attention to one's appearance), while the intellect is highly developed (although singularly applied to material pursuits).[59] The newspaper clippings and other sources cited by the critics had amply illustrated that the negative qualities both psychiatrists had observed in the Indonesians were present in the Dutch to a highly comparable degree. Consequently, they concluded that the observations provided by both psychiatrists did not provide any reason for conclusions about the nature of the native psyche.

The critics did not denounce the project of developing a psychology of the Indonesian people. The foremost requirement was that it should be conducted in a truly scientific spirit, which meant that indigenous physicians had to conduct this research because of their knowledge of the languages, the culture, and the history of the subjects in this investigation. Individuals had to be investigated in their natural circumstances. Latumeten, in a report for the Association of Indigenous Physicians, argued for the absolute necessity of the establishment of a psychiatric clinic near the STOVIA. Clinical instruction in psychiatry and neurology

in the former Dutch East Indies had been severely deficient; van Loon had earlier complained that it was impossible to bring highly disturbed patients to the classroom from the institution he ran about 20 kilometres away.[60] Although everybody in the medical school agreed that this situation was undesirable, no initiative was taken to rectify it. Proposals to dedicate a ward of the local hospital as a psychopathic ward were rejected because 'one should not mix the sick and the insane.'[61] Apart from providing essential support for the teaching of psychiatry and neurology, Latumeten argued, it would also enable physicians to collect data on the nature of the indigenous mind, about which so little was known.

The members of the *Indonesiche Vereeniging* invited van Loon to discuss his lecture with him in more detail. On the 14th of June, this meeting took place in The Hague. After briefly repeating his conclusions, van Loon apparently felt very uncomfortable during the discussion and left the meeting prematurely and under false pretense.[62] Apparently, a dialogue between van Loon and a group of highly educated Indonesians could not take place. The dispute with the Dutch psychiatrists reverberated for a long time among Indonesian physicians and nationalists and was repeatedly discussed among the Association of Indies physicians as one of the prime examples why their presence in the archipelago was essential (other topics were pay and reimbursement, pensions, and the indigenous physician's uniform). At the end of the first Congress of the Association, held in 1938, a long presentation on psychiatric views on the native mind was given.[63] At its conclusion, the following resolution was presented:

> The pronouncements by psychiatrists about the psyche and the mental life of the indigenous population of the Dutch East Indies have been premature. This topic requires extensive and careful study. When judging such pronouncements, it is important to place the pronouncements of Indonesian scholars side by side to European ones.[64]

The project of developing a psychology of Indonesians was not dismissed as an oppressive colonial tool. It was instead taken as an argument for the development of Indonesian scholars and physicians and the creation of research facilities in the Indies to be staffed by Indonesians. In other words, this was an argument for the modernisation of Indonesia.

## Psychology and colonisation

One of the most prominent critics of the Dutch colonial government was Mohammad Hatta, who, together with Sukarno, proclaimed the

independence of the Republic of Indonesia on 17 August 1945, a few days after the capitulation of the Japanese.[65] Hatta studied economics in the Netherlands from 1923 to 1932 and was active in the *Indonesiche Vereeniging*, where he frequently interacted with the physicians who wrote the writ of defence and the articles in *Indonesia Merdeka*. Partly because of Hatta's influence, the *Indonesische Vereeniging* was transformed into one of the most radical Indonesian political groups at the time, strongly advocating the principle of non-cooperation. In 1924, it adopted the independence of Indonesia as its ultimate aim and renamed itself *Perhimpoenan Indonesia*, a Malay name, a year later, since its members envisaged that Malay would become the unifying language of the independent republic of Indonesia.[66]

Because of his own writings in *Indonesia Merdeka*, Hatta was arrested in 1927 for disturbing the public order and inciting political agitation. In his famous defense speech, *Free Indonesia,* he highlighted the damaging psychological consequences of the colonial political structure on the psyche of the indigenous population: 'The spiritual structure of the nation has been changed. Its personality is temporarily broken.'[67] This had led to a general passivity among Indonesians, a state of affairs which greatly facilitated maintaining colonial society. Apart from the power of the army, the police, and an absolute control over the economy, Hatta argued that colonial society was also buttressed by 'various *psychological* factors of power on which the authority and prestige of the ruler rests.'[68] Apart from keeping the masses ignorant and proclaiming a policy of association, Hatta mentioned the 'psychological injection of the idea of superiority of the white race and of the unassailability of its position' as well as the 'injection of the idea of national impotence of the Indonesians.'[69] These ideas served significant ideological functions in the Dutch colonial society.

The ideas of white superiority, presented with the authority of science and part and parcel of everyday parlance in the Dutch East Indies, were an essential part of the ideology of a colonial society. As Hatta put it:

> For years the Indonesians have lived under this colonial hypnosis, until in the end they also believed in their own impotence and that the ruler was indispensable to give the country leadership .... Day in day out it has been emphasised that the Indonesians do not possess the capacities for leadership and that they are not capable of initiative, so that really they are predestined from the day of their birth to work under European leadership.[70]

Hatta's principle of non-cooperation was largely inspired to effect 'a systematic destruction of the psychological foundations on which the authority and respect of the ruler are partly based.'[71] It was, first of all, based on a desire to give the Indonesian population self-confidence. To counteract the damaging psychological effects of Dutch colonial rule, the ideology of superiority of the white races, buttressed by colonial psychiatrists and physicians, had to be challenged. Anthropologists, ethnologists, sociologists, linguists, physicians, psychiatrists, and psychologists buttressed these views and gave them an aura of scientific credibility, while actually contributing to the colonial ideology based on inequality, racial discrimination, economic exploitation, and political repression.

Hatta's awareness of the psychological consequences of colonisation must have been heightened by the discussions of these matters among his fellow members of the *Indonesiche Vereeniging*. His political perspective was reflected in their writings. They form one of the earliest sustained analyses of the psychological consequences of colonisation and a critique of the role of colonial psychiatry. These issues have become familiar through the writings of the Algerian psychiatrist Franz Fanon in the 1950s.[72] The critique by Indonesian physicians of colonial Dutch psychiatry preceded Fanon's work by at least three decades.

## Conclusion

Theories on the nature of the indigenous psyche were propagated in the Dutch East Indies after the colonial government had ended the dialogue with the various nationalist movements and had instituted repressive measures against them. The enormous popularity of the *Politiek Economischen Bond* indicated that most Dutch colonialists endorsed these reactionary trends. The PEB portrayed the representatives of the nationalist movements as alienated intellectuals who had lost their roots and were therefore no longer representative of the common people. Instead of continuing a dialogue with the indigenous movement, members and sympathisers of the PEB argued that its needs, desires, and wishes could only be known through scientific research, which constituted a monologue of colonial scientists about the natives in which no native had a voice. Because of the strong association between reactionary political ideas and theories on the nature of the indigenous psyche, the critics of the Dutch colonial supremacy and advocates of non-cooperation felt compelled to deconstruct these views. This led to a highly articulate, original, and sustained critique of psychiatry as a colonial ideology.

## Notes

1. Pramoedya Ananta Toer, *House of Glass* (New York: 1997 [1988]), p. 62. STOVIA stands for *School ter Opleding van Inlansche Artsen*, the School for the Education of Indigenous Physicians. The 'I' in the quote is the character of Pangemanann, member of the *Algemeene Secretariaat*, who collects intelligence and monitors the nationalist movements in the Dutch East Indies. Pangemanann made a special study of Tirto Ady Suryo, who was a student at the STOVIA for a few years and who became one of the first nationalist leaders of Indonesia. Toer's *Buru Quarter* is a literary rendition of Tirto's biography.
2. See Frances Gouda, *Dutch Culture Overseas: Colonial Practice in the Netherlands Indies, 1900–1942* (Amsterdam: 1995), pp. 24–27. The principles of the ethical policy were most clearly outlined in Conrad Theodor van Deventer, '*Een Ereschuld* [A Debt of Honour],' *Indische Gids*, 3 (1899) 205–57.
3. Robert van Niel, *The Emergence of the Modern Indonesian Elite* (The Hague: 1960), places the demise of the ethical culture in 1920.
4. *Ter Kennismaking met den Ned.-Ind. Politiek Economischen Bond [An Introduction to the PEB]* (Weltevreden: 1919). The founder of the PEB, C. Lulofs, stated that 'He placed himself on the side of the ethnological school, which teaches that significant racial and character differences often create an unbridgeable chasm divide that separates the main racial groups.' (p. 28).
5. For the STOVIA, see A.M. Luyendijk-Elshout, ed., *Dutch Medicine in the Malay Archipelago, 1816–1942* (Amsterdam: 1989); A. de Knecht-van Eekelen, 'Tropische Geneeskunde in Nederland en Koloniale Geneeskunde in Nederland-Indie,' *Tijdschrift voor Geschiedenis* 105, 3 (1992) 407–28; and A. de Waart, ed., *Ontwikkeling van het Geneeskundig Onderwijs te Weltevreden, 1851–1926 (Uitgave ter Herdenking van het 75–Jarig Bestaan van de School tot Opleiding van Indische Artsen (STOVIA))* (Weltevreden: 1926). Today, the buildings which once housed the medical school are now home to the Kebangkitan Nasional [Museum of National Awakening], which celebrates the founding of Budi Utomo, the first nationalist movement in 1908, and the significant involvement of physicians in the nationalist movements of Indonesia.
6. P.H.M. Travaglino, 'Politiek en Psychologie [Politics and Psychology],' *PEB: Orgaan van den Nederlandsch-Indischen Politiek-Economischen Bond*, 5, 8 (1924) 89.
7. Ibid., 87. Travaglino was not the first physician to argue for a psychological colonial policy. See, for example, J.H.F. Kohlbrugge, *Blikken in het Zieleleven van den Javaan en Zijner Overheerschers [Views on the Mental Life of the Javanese and Their Rulers]* (Leiden: 1907); J.H.F. Kohlbrugge, 'Psychologische Koloniale Politiek [Psychological Colonial Policy],' *Vereeniging Moederland en Koloniën*, 8, 2 (1907) 1–44; J.H.F. Kohlbrugge, Zielkunde Als Grondslag Van Koloniaal Beleid [Psychology as a Foundation for Colonial Policy],' *De Militaire Gids: Orgaan voor Weermacht en Natie*, 27 (1908) 229–51.
8. Travaglino, 'Politiek En Psychologie,' 88.
9. Travaglino had elaborated on this topic previously: P.H.M. Travaglino, 'Het Karakter Van Den Inlander [The Character of the Native],' *PEB: Orgaan van den Ned.-Ind. Politiek-Ekonomischen Bond* 5, 27 and 28 (1920) 343–47; 357–60.

10. Travaglino had reported these findings earlier in the medical press: P.H.M Travaglino, 'De Psychose van den Inlander in verband met Zijn Karakter [The Psychosis of the Native in Relation to His Character],' *Geneeskundig Tijdschrift voor Nederlands Indië*, 60 (1920) 99–111; P.H.M. Travaglino, 'De Sociale Beteekenis der Schizophrenie voor de Inlandsche Samenleving [The Social Meaning of Schizophrenia for Indigenous Society],' *Mededeelingen van den Dienst der Volksgezondheid in Nederlandsch-Indië*, 2 (1925) 125–131; P.M.H. Travaglino, 'De Schizophrenie en de Javaanse Psyche [Schizophrenia and the Javanese Psyche],' *Psychiatrische en Neurologische Bladen*, 31 (1927) 416–25.
11. Christoph Bendick, *Emil Kraepelins Forschungsreise nach Java 1904: Ein Beitrag zur Geschichte der Ethnopsychiatrie*, vol. 49, *Kölner Medizinhistorische Beiträge* (Köln: Institut für Geschichte der Medizin der Universität Köln, 1989). The mental hospital near Buitenzorg had opened in 1882; for an overview of its early history see Johan Wilhelm Hofmann, *Bericht ueber Die Landesirrenanstalt in Buitenzorg (Java, Niederl.-Ostindien) Von 1894 Bis Anfang Juli 1901* (Batavia: 1902).
12. Emil Kraepelin, 'Vergleichende Psychiatrie,' *Centralblad für Nervenheilkunde und Psychiatrie*, 27 (1904) 433–37; Emil Kraepelin, 'Psychiatrisches Aus Java,' *Centralblad für Nervenheilkunde und Psychiatrie*, 15 (1904) 468–469. Several commentators have later claimed that Kraepelin's visit to Java constituted the birth of comparative or cross-cultural psychiatry. See, for example, Alexander Boroffka, 'Emil Kraepelin (1856–1926) and Transcultural Psychiatry: A Historical Note,' *Transcultural Psychiatric Research Review*, 25 (1988) 236–39; Wolfgang G. Jilek, 'Emil Kraepelin and Comparative Sociocultural Psychiatry,' *European Archives of Psychiatry and Clinical Neuroscience*, 245 (1995) 231–38; for a broader history see Ana Maria G. Raimundo Oda, Claudio Eduardo M. Banzato, and Paulo Dalgalarrondo, 'Some Origins of Cross-Cultural Psychiatry,' *History of Psychiatry*, 16 (2005) 155–69.
13. Kraepelin's ideas on *Völkerpsychologie* were inspired by his former teacher Wilhelm Wundt. See Rainer Diriwachter, 'Volkerpsychologie: The Synthesis That Never Was,' *Culture & Psychology*, 10, 1 (2004) 85–109.
14. P.H.M. Travaglino, 'Het Karakter Van Den Inlander [The Character of the Native],' *PEB: Orgaan van den Nederlandsch-Indischen Politiek-Ekonomischen Bond*, 5, 28 (1920) 359.
15. See Gouda, *Dutch Culture Overseas*, in particular Chapter 4, 'The Native "Other" as the Medieval, Childlike, and Animal "Self" (or as Fundamentally Different): Evolutionary Ideas in Dutch Colonial Rhetoric in Indonesia'; and Jan Breman, ed., *Imperial Monkey Business: Racial Supremacy in Social Darwinist Theory and Colonial Practice* (Amsterdam: 1990).
16. Arnold van Gennep, 'Voordracht, 6e Vergadering, Woensdag 15 Juni [Address],' *Handelingen van den Volksraad* (1921) 133–42.
17. 'Wetenschappelijke Grondslag Eener Ontwikkelingspolitiek [Scientific Foundation for Developmental Policy],' *Handelingen van den Volksraad*, no. 1e gewone zitting (1921): Onderdeel 1, Afdeeling 1, stuk 6; p. 12.
18. See J.F. Holleman, ed., *Van Vollenhoven on Indonesian Adat Law* (The Hague: 1981).

19. F.H. van Loon, 'Het Onderwijs in De Zenuw-En Zielziekten [Education in Neurology and Psychiatry],' in *Ontwikkeling Van Het Geneeskundig Onderwijs Te Weltevreden, 1851–1926*, ed. A. de Waart (Weltevreden: 1926), p. 209.
20. For similar observations in an entirely different colonial context, see Jonathan Sadowsky, 'Psychiatry and Colonial Ideology in Nigeria,' *Bulletin of the History of Medicine*, 71, 1 (1997) 94–111.
21. F.H.G. van Loon, 'De Psychische Eigenschappen der Maleische Rassen (Vergadering van 22 Februari 1924) [The Mental Characteristics of the Malay Races],' *Indisch Genootschap: Verslagen der Vergaderingen* (1924) 23.
22. See Nikolas Rose, *Powers of Freedom: Reframing Political Thought* (Cambridge: 1999) for similar thoughts on the government of Western countries. The need and desire to acquire knowledge of the indigenous population not only reflects this trend in Western societies, but also reflects the specific political situation in the Dutch East Indies in the 1920s.
23. Van Loon elaborated on these findings in his many other articles, among them F.H.G. van Loon, 'Acute Verwardheidstoestanden in Nederlands-Indie [Acute States of Confusion in the Dutch East Indies],' *Tijdschrift voor Geneeksunde in Nederlands Indië*, 62 (1922) 658–90; F.H.G. van Loon, 'Amok and Lattah,' *Journal of Abnormal & Social Psychology*, 4 (1927) 434–44; F.H.G. van Loon, 'Rassenpsychologische Onderzoekingen [Investigations in Racial Psychology],' *Psychiatrische en Neurologische Bladen*, 32 (1928)190–26; F.H.G. van Loon, 'Protopathic–Instinctive Phenomena in Normal and Pathological Malay Life,' *British Journal of Medical Psychology*, 8 (1928) 264–76.
24. van Loon, 'Psychische Eigenschappen Maleische Rassen,' 38.
25. Kohlbrugge, *Blikken in het Zieleleven van den Javaan;* Kohlbrugge, 'Psychologische Koloniale Politiek [Psychological Colonial Policy].'
26. Akira Nagazumi, *The Dawn of Indonesian Nationalism: The Early Years of the Budi Utomo, 1908–1918*, vol. 10, *I.D.E. Occasional Papers Series* (Tokyo: Institute of Developing Economies, 1972).
27. See Eekelen, 'Tropische Geneeskunde in Nederland en Koloniale Geneeskunde in Nederland-Indië.' For the Society for Indigenous Physicians see: *Jubileumnummer 1911–1936: Orgaan Vereeniging van Indische Geneeskundigen* (Batavia: 1937), in particular W.H. Tehupeiory, 'Onze Vereening: De Voorgeschiedenis van Hare Oprichting en Hare Kleuterjaren,' in *Jubileumnummer 1911–1936: Orgaan Vereeniging Van Indische Geneeskundigen* (Batavia: 1937); and J. Kayadoe, 'Uit Roerige Jaren,' in *Jubileumnummer 1911–1936: Orgaan Vereeniging Van Indische Geneeskundigen* (Batavia: 1937).
28. After 2 years of study in the Netherlands, Indonesian physicians qualified for the official title of physician. For an engaging account of two of the very first medical graduates of the STOVIA who went to the Netherlands for further study, the brothers Tehupeiory, see the following historical novel: Herman Keppy, *Tussen Ambon en Amsterdam* (Amsterdam: 2004).
29. For the *Perhimpunan Indonesia,* see John Ingleson, *Perhimpunan Indonesia and the Indonesian Nationalist Movement, 1923–1928*, vol. 4, *Monash Papers on Southeast Asia* (Clayton VIC: Centre of Southeast Asian Studies, Monash University, 1975), and Harry A. Poeze, *In het Land van de Overheerser I. Indonesiërs in Nederland, 1600–1950* (Dordrecht: 1986).

30. 'Politiek en Psychologie, *Vervolg* [Politics and Psychology, *Continued*],' *PEB: Orgaan van den Ned.-Ind. Politiek-Ekonomischen Bond*, 5, 8 (1924) 99–100.
31. Ibid., 100.
32. van Loon, 'Psychische Eigenschappen Maleische Rassen,' 43. The first person to speak was Dr. H. Bervoets, who organised medical supplies to be sent to Dutch-reformed medical missionaries in the Indies.
33. Ibid., 45. This speaker was an engineer, P.J. Ott de Vries, an expert on irrigation in the Dutch East Indies.
34. As quoted in: 'Kemadjoean Hindia,' *Overzicht van de Inlandsche en Maleisch-Chineesche Pers*, 50 (1923) 604–05: 604.
35. Ibid., 605.
36. 'Sinar Hindia,' *Overzicht van de Inlandsche en Maleisch-Chineesche Pers*, 1 (1924) 18: 18.
37. 'Psychiatrisch Fascisme [Psychiatric Fascism],' *De Taak* 7, 311 (1924) 1809–1811.
38. Ibid., 1810.
39. The following information is derived from Joost Coté, 'Colonial Designs: Thomas Karsten and the Planning of Urban Indonesia,' *Paper presented to the 15th Biennial ASAA Conference, Canberra, 28–31 June 2004* (2004).
40. Bond van Indonesische Artsen (Afdeeling Nederland), *Verweerschrift tegen de Rede van Dr. F.H. van Loon over 'De Psychische Eigenschappen der Maleische Rassen,' Uitgesproken op de Vergadering van het Indische Genootschap in Den Haag op den 22sten Febuari 1924 [Writ of Defense]*, Vol. 1, *Publicatie van de Bond van Indonesische Artsen, Afdeeling Nederland* (Amsterdam: 1924).
41. Latumeten is the only physician who can be identified as one of the co-authors of the pamphlet. He had finished his studies at the STOVIA in 1907 and spent 1922 to 1924 in the Netherlands writing his dissertation on a psychiatric topic, which he defended in June 1924. Upon his return to the Indies, he became the medical superintendent of the mental hospital at Sabang, north of Sumatra. In 1945, he was working in the newly established Ministry of Health in Jakarta. J.B. Sitalana was for further study in the Netherlands in the early 1920s and later specialised in the treatment of leprosy. Sukiman Wirjosandjojo was a Member of Parliament and sometime prime minister after 1949. They were also members of the Indonesische Vereeniging.
42. 'Dilettantisme of Wetenschap? [Amateurism or Science?],' *Indonesia Merdeka,* 2 (1924); 'Enkele Opmerkingen naar aanleiding van de Rede van Dr. F.H. van Loon: 'De Psychische Eigenschapen der Maleische Rassen' voor het Indische Genootschap d.d. 22 Februari 1924 en de door Hem daarop Gegeven 'Nadere Toelichtingen' voor de Indonesische Vereeniging d.d. 14 Juni 1924 [Comments on the Lecture of Dr. F.H. van Loon and Further Explanations Provided by Him],' *Indonesia* Merdeka, 2 (1924) 51–66; 'Modern Evangelie: Penneprikjes naar aanleiding van V. Loon's Rede in Den Haag op 14 Juni 1924 [Modern Gospel: Comments],' *Indonesia Merdeka*, 2 (1924) 66–68; 'Verdere Opmerkingen naar aanleiding van De Rede van Dr. F.H. van Loon: 'De Psychische Eigenschapen der Maleische Rassen' [Further Comments], *Indonesia Merdeka*, 2 (1924) 79–91.
43. 'Nogmaals Dr. van Loon! [Again Dr. van Loon!],' *Orgaan der Vereeniging van Indische Geneeskundigen*, 15, 1 (1925) 41–6.

44. 'De Psychische Eigenschappen der Maleische Rassen [The Mental Characteristics of the Malay Races],' *Orgaan der Vereeniging van Indische Geneeskundigen,* 5, 1 (1925) 36–40.
45. 'Enkele Opmerkingen,' 56.
46. See Bond van Indonesische Artsen (Afdeeling Nederland), *Verweerschrift*, 3.
47. Ibid. 'Psychische Eigenschappen Maleische Rassen,' 36.
48. van Loon, 'Psychische Eigenschappen Maleische Rassen,' 47.
49. J.A. Latumeten, 'De Beteekenis van het Psychiatrisch-Klinische Onderwijs Voor Indonesië [The Importance of Clinical Education in Psychiatry for Indonesia].' *Orgaan der Vereeniging van Indische Geneeskundigen* 16, 2 (1928) 31.
50. 'Enkele Opmerkingen,' 60.
51. Bond van Indonesische Artsen (Afdeeling Nederland), *Verweerschrift*, 1, i.
52. 'Verdere Opmerkingen,' 81.
53. Bond van Indonesische Artsen (Afdeeling Nederland), *Verweerschrift*, 3.
54. Ibid., 3.
55. Ibid., 6, 7.
56. See Edward W. Said, *Orientalism* (New York: 1978).
57. Bond van Indonesische Artsen (Afdeeling Nederland). *Verweerschrift,* p. 15.
58. Quoted in: Bond van Indonesische Artsen (Afdeeling Nederland), *Verweerschrift*, p. 11.
59. 'Enkele Opmerkingen,' 64.
60. F.H. van Loon. 'Het Onderwijs in de Zenuw-En Zielziekten.' In *Ontwikkeling van het Geneeskundig Onderwijs te Weltevreden, 1851–1926*, edited by A. de Waart (Weltevreden: 1926), pp. 209–14.
61. J.A. Latumeten, 'De Beteekenis van het Psychiatrisch-Klinische Onderwijs voor Indonesië [The Importance of Clinical Education in Psychiatry for Indonesia],' *Orgaan der Vereeniging van Indische Geneeskundigen*, 16, 2 (1928) 25–38: 29.
62. Reported in 'Enkele Opmerkingen' and 'Verdere Opmerkingen.'
63. J.B. Sitanala, 'Beschouwt de Oosterling "Arbeid" als een "Vloek" des Heeren? [Do Eastern Individuals View Labour as a Curse of the Lord],' in *Het Eerste Congress van de Vereeniging van Indonesische Geneeskundigen Gehouden op 24, 25, En 26 December 1938 te Semarang* (Batavia: 1938).
64. *Het Eerste Congress van de Vereeniging van Indonesische Geneeskundigen Gehouden op 24, 25, En 26 December 1938 te Semarang [First Congress of the Association of Indonesian Physicians]* (Batavia: 1938), p. 184.
65. For the autobiography of Hatta see: Mohammad Hatta, *Mohammad Hatta, Indonesian Patriot: Memoirs*, C.L.M. Penders ed. (Singapore: 1981).
66. For Perhimpunan Indonesia, see Ingleson, *Perhimpunan Indonesia and the Indonesian Nationalist Movement, 1923–1928*. For the increasingly radical views of this group see Indonesiche Vereeniging, *Gedenkboek 1908–1923 [Memorial Volume 1908–1923]* (Den Haag: 1924). For Indonesian organisations in the Netherlands see: Poeze, *In het Land van de Overheerser I. Indonesiërs in Nederland, 1600–1950*.
67. Mohammad Hatta, 'Indonesië Vrij,' in *Verspreide Geschriften* (Jakarta: 1952), 254; my translation. See also Mohammad Hatta, *Portrait of a Patriot: Selected Writings* (The Hague: 1972), p. 245.

68. Mohammad Hatta, ‘Indonesia Free’ in *Portrait of a Patriot: Selected Writings* (The Hague: 1972), 258–59; see also Hatta, ‘Indonesië Vrij,’ 269.
69. Hatta, ‘Indonesia Free,’ 259.
70. Ibid., 266–67.
71. Ibid., 272.
72. Frantz Fanon, *Black Skin, White Masks*, trans. Charles Lam Markmann (New York: 1967); Frantz Fanon, *The Wretched of the Earth*, trans. Constance Farrington (New York: 1965).

# 9

# Imperial Networks and Postcolonial Independence: The Transition from Colonial to Transcultural Psychiatry

*Alice Bullard*

This essay seeks out continuities and discontinuities in the transition from colonial to post-colonial psychiatry. It seems important, if somewhat obvious, to point out that in the transition from colonial to post-colonial both Senegal and France were transformed. To be sure, Senegal's independence figured more weightily in Senegal than in France, but then Senegal was only one many colonies that France lost in those years, so it is not an exaggeration to speak of parallel if not identical transformations. Colonial psychiatry transformed into a diverse range of practices, ranging from collaborations with traditional healing to biomedical, pharmaceutical-based psychiatry. Transcultural psychiatry occupies a mid-range in this spectrum; committed wholly neither to Western nor to Senegalese culture, it reaches out, seeking to bridge differences in beliefs and practices related to spirit, psyche, healing and wellness. Transcultural psychiatry here is distinguished from 'ethnopsychiatry,' understood as the project launched by Georges Devereux of recuperating entire healing systems from non-Western cultures.[1] Transcultural psychiatry is a practice which involves and interests Senegal and France (as well, to be sure, as other countries). Its emergence demonstrates how, in the psychiatric arena during the transition to post-colonialism, neither Senegal nor France emerged as less caught up in an inter-connecting set of relations. The web of science and scientific institutions continued to link them directly (notably via the University of Dakar and other French-sponsored research organizations) and to link each (in different ways) into public and private international institutions (most notably the World Health Organization (WHO), yet

also the World Bank, and a plethora of private foundations) and to international scientific personnel. Transcultural psychiatry inhabits a world as well in which immigration to France (or Canada, or to a lesser extent, the US) motivates the growth of this field of health science. Created in the early years of Senegal's independence, transcultural psychiatry is now vital in France, in Canada, and in the vast and ever changing platforms of humanitarian psychiatry.

Colonial psychiatry generally produced knowledge while intentionally ignoring or dismissing local beliefs and practices; post-colonial transcultural psychiatry has reversed this, so that local beliefs and practices including culturally specific healing practices inform and sometimes guide transcultural therapeutic interventions. This transformation is rooted in ways of knowing, in evolving scientific practices and codes of ethics.

In *La Folie au Sénégal*, Mamdou Diouff and Mohamed MBodj argue that under colonialism the wholesale imposition of Western medical knowledge on the Senegalese tended toward the destruction of traditional beliefs and the negation of indigenous culture.[2] Traces of such subjugation are found in colonial era laws that prohibited practicing medicine without a license, and that assigned fines and imprisonment for those who accused others of witchcraft.[3] In *Black Death, White Medicine*, Myron Echenberg provided testimony from healers who feared to practice because of the threat of colonial state reprisals.[4] Such prohibitions, when effective, excised the very heart of the various West African healing practices. Illness, madness or death, in these cultures, always arose as an act of aggression. Aggression by the living included cannibalistic witchcraft or magic by a marabout or sorcerer. Aggression by the dead took the form of possession by spirits known, for example, as *rab* or *djinn*.[5] Only a healer skilled at divination could discover the source of aggression, and thereby follow the proper curative rite. However, colonial laws prevented divination and the subsequent identification of the responsible party. In effect, then, colonial laws hampered healers, while leaving witches and sorcerers largely free to act without fear of being detected, thereby abandoning the broader population into the hands of the evil doers.[6]

The *samp* and *ndoep*, practiced by the Lebou, exemplify the type of healing rituals used in Senegal to succor someone suffering an episode of madness. West African cultures in general viewed madness as an event which involved the extended family and community. The 'mad' person conveyed a message to the group—perhaps a message from an

ancestral spirit, or perhaps a message from a witch. The healer mediated between the messenger, the mad individual, and the community. Through extensive inquiries and investigations followed by purifying rituals, the healer worked to re-establish a social equilibrium. Europeans in the colonial era, however, did not study or understand these rituals. The psychologists and psychiatrists at the Fann Hospital in Dakar in the early 1960s produced the earliest scholarly explorations of them.[7] Hence, although some French colonials understood that West Africans linked spirituality, magic and medicine, the impulse to link Western medicine with African healing was absent. Henri Labouret working with the informant and interpreter Moussa Travélé, for example, published an extensive study of magic in the French Sudan in 1927.[8] This long study documents the variety of amulets and their supposed powers found in the market at Bamako and in the surrounding region. Their report reproduced testimonies from informants in Bambara, in order to provide linguistic details along with their extensive sketches of amulets. Charles Monteil's 1931 study of divination in the AOF sought to represent the role of magic in African thinking, but sought to apply this to governmental strategies rather than to the practice of medicine.[9] Such studies of magic and 'superstitions' tied French colonial knowledge of West Africa to North African cultural and colonial traditions. For example, the posthumous publication of Dr. Emile Mauchamp, *La Sorcellerie au Maroc*, documented various magical medical practices, but aimed to expose superstition and ignorance, rather than to build a bridge between medical practices. In 1907 Mauchamp was murdered by a mob in Marrekesh, reportedly after a German spy spread rumors that Mauchamp's medical skills included the ability to administer poison that took 2 or 3 years to be fatal.[10] The French then took this murder as a pretext for expanding colonial rule. As Mauchamp's father opined, it was time for France to clean up the moral miasma which caused Moroccans to rot and become ferocious.[11]

An enormous gulf separated the outlawed traditional healers of the colonial era from psychiatric practice in the colonies of West Africa. In general mental illness among Africans was nearly invisible to the colonial authorities. Traditional healers and marabouts had highly developed techniques for caring for the mentally ill, who usually were reintegrated back into their families and villages. Only the most severely stricken would have become errant vagabonds and drawn the attention of the authorities.[12] One French perspective on the treatments given by African healers in AEF was represented by M. le Médecin-Major Huot's report from Loango:

> We do not not, we cannot know, the actual number of the mentally ill among the free population in the villages; all of the ill in this category are carefully isolated and hidden by the fetishers. However, the number must be relatively high, especially in the area of Loango, and there is an imperative, perhaps in Gabon more so than in other places, to take measures to protect this type of sick native, to remove them from the power [*regime* in the original] of a revolting barbarity which is imposed on them by the fetishers.[13]

If French doctors desired to treat Africans who suffered mental illness, this humanitarian impulse was stymied by lack of access to potential patients and lack of medical and material resources. Until well after First World War, little psychiatric care was available to Africans in the AOF, and none at all in the AEF. Indeed, the most substantial report on mental illness from French West Africa or French Equatorial Africa came from experts on sleeping sickness, Doctors Gustave Martin and Ringenbach. Working at the Pasteur Institut in Brazzaville, these doctors produced a compelling study of the psychic disturbances suffered in advanced sleeping sickness.[14] Despite the vivid depictions of delusions, hallucinations, and witchcraft accusations, this work was not integrated into any psychiatric protocol.

In the colonial era, Europeans who suffered more than a casual bout of mental illness were shipped back to Europe. Nonetheless, some internment of mentally-ill Africans and Europeans took place in miserable, locked cells on hospital grounds in Dakar, on Goree Island, and in Saint-Louis. Those unlucky enough to suffer internment generally led the life of a prisoner, confined to a small, dank cell with little if any furniture and fed the most meager of diets. Repeated objections by doctors to this non-therapeutic incarceration led colonial officials to develop a plan to transport mental patients to France. From 1894–1917, interned Africans who suffered chronic mental illness were subject to transportation to locked asylums in Marseille and Aix-en-Provence.[15] This system of transportation proved a costly embarrassment to the government. Of the 126 West Africans shipped to Marseille from 1897–1911, 94 died; a death rate of 74 per cent, with tuberculosis cited as the mortal factor in over 50 per cent of the cases.[16] Transportation simply replaced miserable incarceration in Senegal with more lethal incarceration in southern France. No interpreters travelled with patients to France, leaving doctors completely unable to communicate with their charges, who suffered deeply from the change of climate, dress, customs and diet.

The first sustained exposure of French psychiatrists to mentally-ill Black Africans was during First World War. The *tirailleurs senegalaise* who fought for the French suffered psychological wounds from the war, just as soldiers from the other countries. Angelo Hesnard collaborated with Antoine Porot to write two books on mental illness during the war, and in these short treatises we find descriptions of Black Africans' responses to the war.[17] Hesnard figures large in the history of psychoanalysis in France; his 1914 book co-authored with his mentor Emmanuel Régis, *Psychoanalyse des névroses et des psychoses*, is credited with bringing Freudian analysis into the French psychiatric community.[18] Porot, the leader of the 'Algiers School' of colonial psychiatry, has a reputation for biological racism that in retrospect makes him an unlikely collaborator with Hesnard. However, Hesnard's work in colonial psychiatry was less prominent than his position in the psycho-analytic community. He founded the Société psychanalytique of Paris, and the société de l'évolution psychiatrique; he eventually rose to be a Colonel in the Navy. He was a student and follower of Emmanuel Régis, who with Henri Reboul wrote a comprehensive study of French colonial psychiatry in 1912.[19] At the time of his collaboration with Porot, Hesnard was a médecin de 1er classe de la Marine, and specialist in Neuro-psychiatry. Porot had already served as the head of the medical center at Lyon; during First World War he directed a military neuro-psychiatric clinic.

The collaboration between Porot and Hesnard linked the psychiatry of Black Africans with that of North Africans. According to Hesnard and Porot, violent outbursts, mania, deliriums of persecution, and anxious melancholia characterized the pathological reactions of Black soldiers to warfare. These reactions were 'noisy and ephemeral and often susceptible to cure in the hospital.' Above all, remarked Porot and Hesnard, the continued mental health of the Black troops depended on their milieu, 'it is important not to let them feel uprooted and so to group them according to their home regions and dialects.'[20]

In their second book, *Psychiatrie de Guerre*, the two doctors described 'Blacks and Senegalese' in direct comparison to North Africans. True to the scandalous reputation of colonial psychiatry, the description of North Africans contains just about every racial slur imaginable.[21] The description of Black Africans follows, opening with a comment about how the 'puérilisme' of Blacks is even greater than among North Africans; 'They are more openly childish in their manners and reactions, but they are more lively and do not have this deep reserve of resigned passivity that the Muslims have.'[22]

During the colonial era, the African healers were subject to prosecution for practicing, while psychiatric treatment for Africans was largely unavailable, and if available, was often lethal or at best, of questionable merit. The post-colonial era marked a dramatic shift, with the sudden valourization of traditional healers by the director of the major psychiatric hospital in Dakar, and a host of subsequent changes. Yet the era of independence was not one in which France and West Africa (or, Senegal) became free of mutual ties and influences. Continued clientele relations and the growing influence of a host of international organizations, ensured that the influential Fann psychiatric hospital in post-colonial Dakar developed in a web of local and international interests.

As the AOF slowly severed its ties with France, one of the French tactics for maintaining ties in the region was to create the University of Dakar. It is insufficient to state that the French endowed the university: they built it, they financed it and they staffed it with French professors and researchers. The Fann psychiatric hospital was housed at the university hospital; Dr. Henri Collomb became the first director of the facility, thriving in his post for 20 years.[23]

A military appointment was the norm for doctors, including psychiatrists, in the French colonies.[24] Collomb was not an exception; he was a product of a network of colonial, military, psychiatrists. Collomb studied medicine at a military school (l'École du Service de santé de la Marine et des Troupes Coloniales in Bordeaux) and later taught at l'École d'Application du Service de Santé de la France d'Outre-Mer. He began his appointment at Fann as a Lieutenant Colonel and during his 20 years at Fann Hospital, he continued to rise through the military ranks. He was promoted to Doctor Colonel in 1962, then to Doctor General in 1966.[25] Collomb's salary at Fann, along with the salaries of his research team and of the more than 150 other faculty members at the university, was paid by the French state.[26] Funding for the researchers at Fann came largely from the CNRS or from university salaries.[27] Hesnard, introduced previously as Porot's collaborator on First World War psychiatry, was Collomb's training analyst.

Collomb was a military man, an employee of the French state running a psychiatric hospital at a university built, funded, and staffed by the French. All of this makes it historically unlikely that Collomb would be a champion of traditional healing, and a persistent advocate for psychiatric renewal and reform in Senegal. Yet his years at Fann were marked by innovations that continue to provoke interest and admiration. The first president of independent Senegal, Léopold Sedar Senghor praised Collomb by saying that 'like the old Catholic missionaries, he made

himself a Negro with the Negroes.'[28] Senghor extolled Collomb's work for embodying the what he called 'l'ésprit de Dakar,' by which he meant the desire to create an Afro-centered post-colonial nation.[29] Inverting the common assignment of 'tradition' to Africa and humane values to France, Senghor wrote, 'Professor Collomb questioned the traditional [Western] methods of psychiatric medicine . . . following the example of Black African healers he saw patients as ill, not abnormal. And he used the healing methods of Black Africa, that is, healing patients by peaceful methods, using culture and art rather than violence and constraints.'[30]

Innovations under Collomb's leadership included therapeutic programs that integrated local practices into hospital protocol. Motivated by an African acceptance of the 'mad' as especially meaningful members of society, Collomb opposed the isolation and alienation of individuals in asylums and fashioned Fann as an open-door therapeutic center. 'Traditional houses' were constructed in the courtyard of the psychiatric unit. The doctors instituted a type of 'village council' known by the Wolof name of *penc* for the patients and personnel. To integrate the hospital experience into the patient's social world, each patient needed to be accompanied during his or her stay by a family member. The desire to emphasize social context and sense of belonging led Collomb to advocate psychiatric villages (rather than asylums) as the model for care. Finally, in addition to creating a sociable and African atmosphere at Fann, the doctors actively sought information about traditional psychiatric practices and favored integrating traditional healing into the patient's therapeutic regime. They sometimes collaborated directly with traditional healers, and generally worked with an on-going assumption that any patient was likely working with healers alongside their treatment at the hospital.

By 1965 Collomb had established the journal, *Psychopathologie Africaine*, which for the next 10 or 15 years published path-breaking work in transcultural psychiatry. The work accomplished at Fann was distinctive enough to spark the moniker, Fann School. This however gives a misleading sense of unity among the diverse group of researchers at the hospital; it seems preferable to acknowledge the diversity of views and voices and to speak of the Fann group. This group at Fann were largely French or European-derived Francophone (i.e., Belgian or Swiss). Andras Zempleni, a Hungarian whose path-breaking study of samps has already been cited, was a notable exception. Marie-Cécile Ortigues was a French student completing her doctorate in psychology when she joined the clinical team at Fann. Her husband, Edmond Ortigues, directed the Philosophy department at the University. Together the Ortigues wrote

a psycho-analytic study of patients at Fann, *L'Oedipe Africain*. Simone Valantin and Jacqueline Rabain pursued studies of mothers and childhood development.[31] This sampling of the Fann researchers includes just a fraction of the skilled sociologists, psychologists and psychiatrists who spent years of their lives at the hospital. At least one member of this group, René Collignon, a Belgian psychologist who came to Fann in the 1970s, continues to work part of each year at the hospital and currently edits *Psychopathologie Africaine*. Collignon takes a deep interest in the history of psychiatry, and has emerged as the unofficial official historian of Fann.[32]

Collomb addressed the European dominance at Fann by training students drawn from across French-speaking Africa in psychiatry, so that their work becomes increasingly prominent in the journal by the 1970s. Moussa Diop was an early collaborator with Collomb, but he died in 1967. Babakar Diop, a Senegalese Lebou, emerged as the eventual successor to Collomb at Fann. Eric Gbodossou, who had some of his medical training with Collomb, hailed from Benin and went on to become a champion of traditional healing.[33] The role of these men in the post-Collomb years of Fann is explored in this essay's conclusion.

The Fann psychiatric unit replaced the Ambulance du Cap Manuel – a colonial asylum used indiscriminately for such 'dangers to society' as lepers, tuberculosis patients, others with contagious diseases, and those suffering mental illness – was constantly guarded by armed soldiers and cannons.[34] Another asylum, at Dantec hospital, consisted of a cage which confined half-nude men and women, who were prevented from any contact with the outside world. In contrast, Collomb developed Fann as an open facility, which welcomed those seeking aid, their families, and traditional healers in an open-air setting. Proving an exception to the dominant trend of racial stereotyping in colonial psychiatry, Cazanove in the 1920s and 1930s and Aubin in the 1930s–50s called for detailed attention to the role of culture in psychopathology.[35] Cazanove and Aubin recommended that all psychiatrists study ethnography; Aubin went further, advocating developing psychiatric villages in AOF.[36] Building psychiatric villages became favourite projects for Collomb, who much preferred them to asylums and used them as a chance to bring patients into closer contact with their own culture and healing traditions. The colonial disdain for African healers also found some resistance among the French colonists. For example, when legislative proposals were advanced in 1950 that sought to strengthen the prohibitions on '*sorcellerie*,' the anthropologist Marcel Griaule intervened, arguing that in an area with one doctor for every 45,000 people,

healers provided indispensable services.[37] True healers, Griaule claimed, bore little resemblance to the witches whom French colonial law sought to proscribe. Rather, from his perspective the law reflected French ignorance of West African philosophy and social reality. The resonance of Cazanove, Aubin and Griaule with the Fann group demonstrate that their cultivation of local knowledge was not only just an overcoming of the colonial antipathy for African healing, but that it was also continuous with a certain colonial counter-current.[38]

In Nigeria, Dr. Thomas A. Lambo's efforts to accommodate African culture within Western bio-medical psychiatry slightly pre-dated Collomb's efforts, and would likely have influenced his trajectory.[39] But more direct French inspiration for the turn toward African traditional healers is found in the work of French anthropologists such as Jean Rouch and Roger Bastide.[40] In Accra in 1954, Rouch filmed the annual festival of the Hauka religious sect, which became the basis for his 1955 film, *Les maitres fous*. Rouch's film documented the possession crises of the Hauka, pointing to their cathartic and functional dimensions. Similarly, in 1958, Bastide argued persuasively for the psychotherapeutic value of *candomblé*. Prefiguring the Fann group's respect for Serrer and Lebou divination and trance rituals, Bastide argued that, 'contrary to what doctors who first happened upon *candomblé* thought, these rites have a useful role in the mental life their adherents.'

If Collomb and the Fann group followed a counter-current from the colonial era, their cultivation of traditional African healing was also part of a counter-trend to the post-colonial centralizing regimes of the *Diagnostic and Statistical Manual III* (DSM III) and the *International Classification of Diseases* (ICD). In the twilight years of colonialism international organizations, such as the WHO, the World Federation for Mental Health, and the Scientific Council for Africa South of the Sahara, called for integrating local healing into Western medical protocols. At a 1958 conference in Bukavu the final report took note of a widespread interest among psychiatrists in learning from local healing techniques, and recommended further investigation of traditional healing, along with a study of the possibility of the progressive development from one system to the next.[41]

Yet starting in the 1960s, research led by Norman Sartorious at the WHO undertook the creation of a systematized, universal language for mental health diagnosis and treatment. This campaign for international psychiatry has enjoyed many successes, and has positioned a newly universalized language of psychiatric care as the accredited, scientific medium.[42] A new orthodoxy, this time geared toward the needs of

'universal scientific research and a universal language of psychiatry' (and, within the US, of the pharmaceutical industries and insurance companies) replaced the imperial orthodoxy of French supremacy.[43] Efforts at the Fann hospital and the resurgence of traditional healing challenged this post-colonial, techno-science–industrial hegemony.

In an effort to explain his own career path and transformation from colonial military doctor to advocate of 'traditional healers,' Collomb reflected, 'I've been in Africa for many, many years and I've let myself be contaminated. Certain among my colleagues would say that I've lost all scientific judgement and adopted superstitions. Well, I think also that I've reflected long on what goes on around me, and the approach of the healers invited me to think that perhaps something else other than science exists, that explains some types of healing.'[44] He criticized Western psychiatry for 'banishing the spirits' in effect dooming the mad person to becoming a 'nothing' among his family and friends. When they look at the 'crazy' moderns see only illness, nothing else, wrote Collomb, whereas traditional healers saw the mad as messengers from the spirit world.[45]

In one of his most widely read articles, Collomb described what he viewed as the optimal relation of a Western psychiatrist to African cultures.[46] We can take this account as one modelled more or less on Collomb's experience. Every year, recounted Collomb, young Europeans leave for Africa as if they are going on a pilgrimage. Eager for new ways of living, eager to discover values beyond those offered by consumer society, they seek to immerse themselves in Africa, 'what they find is a measure of their own sensiblity, their openness (disponibilité), their own authenticity.' Very few, according to Collomb, are actually capable of immersing in African culture, most 'play with deculturation, more or less fascinated by the desires they project in a society where they are not subject to the constraints of their own culture.'[47]

The psychiatrist who follows this route, according to Collomb, would be able to become a follower of a local healer, and learn his techniques. Once liberated from prejudices that discredit the mentally ill and from Western biological and psychological models, immersion in local healing traditions could allow such a psychiatrist to discover a 'new' psychiatry.[48] However Collomb cautioned that such deep immersion is no less difficult for a psychiatrist than for any other Westerner; despite the best intentions one always remains a foreigner. Moreover, he emphasized that translating the African psychiatry into French forces the recognition that the African beliefs are relatively inaccessible and that they cannot be used by the Western psychiatrist.[49]

Despite these obstacles, Collomb saw real merit in this type of immersion. Beyond the willingness to question one's own culture and Western science, the positive attitude toward healers and toward traditional psychiatry would inevitably influence his psychiatric practice. This influence could foster better relationships with Africans, whether or not they were patients, and could help inform the general organization and goals of his psychiatric practice.

Collomb's desire to bring traditional healing into the psychiatric arena was susceptible to criticism. Edmond Ortigues, Collomb's contemporary and fellow faculty member in Dakar (he was the director of the Department of Philosophy), criticized Collomb for viewing traditional healers as doctors. This was criticism from close quarters, as mentioned previously, Edmond was married to Marie-Cécile Ortigues, who was completing her doctoral residency in psychology under Collomb's supervision at the Fann hospital.[50] To the Ortigues' way of thinking, traditional healers practice religion, and confusing this with medicine does no one any good. The historic link between medicine, magic, and the divine is undeniable and in cultures where these are indissolubly bound up with each other no easy distinction between them can be made.[51] But the Ortigues' point remains worth considering: once the distinction between medicine and religion has been made – as it was in European psychiatry in the nineteenth century – for a Western trained psychiatrist to behave as though it had not risks abandoning science and creating a sentimental medicine.[52]

Among the complications of appropriating 'traditional healing' into a Western medical practice is the likelihood of highjacking 'tradition' from its own meanings and agendas to those of Western bio-medicine. Medical collaboration with traditional healers deliberately appropriates their practices to effect healing. But such collaboration does not participate fully in the rituals and beliefs of the healers. In effect, in collaboration with bio-medicine the healers' art is instrumentalized and shorn of much of its deeper meanings and broader repercussions. The role of the healer as a mediator of social tensions is especially attenuated in Western medical practice that locates disease within an individual body.[53] A good example of this appropriation of healing and turning it from its proper ends is the case of Talla recounted in the Ortigues' *Oedipe Africain*. Commenting on how Talla overcame his possession crises through a combination of psycho-analytic interviews and a traditional *samp*, the Ortigues wax enthusiastic about how he has reached resolution at the level of collective beliefs and also has reached a heightened consciousness of himself. The irony is that traditionally one who underwent a

*samp* ritual became an officiant for the spirits. Talla, however, became a student; he was healed through a *samp*, but the outcome was distinctly modern.[54]

Cultivating a knowledge of 'traditional healing' also involved a problematic project of determining (perhaps unwittingly) what constitutes tradition and who can claim to speak for it. Danielle Storper-Perez, who spent time at Fann as a doctoral student in the early 1970s, developed a searching criticism of the tendency to view tradition outside of historical and political currents that were sweeping through West Africa.[55] Storper-Perez pointed out that the rapid spread of Islam during the colonial era held far-reaching consequences for mental illness, women, and 'tradition.' Islam only recognized the paternal lineage, and hence granted converts autonomy vis-a-vis the maternal lineage.[56] In effect, then, the spread of Islam institutionalized the pre-eminence of men, especially fathers, over women and mothers. According to Storper-Perez, women were the victims of this new social system, because they lost both their personal rights and the support of their brothers, both of which had been inscribed in the pre-Islamic religions. Conversion to Islam was a highly gendered process, because women tended to cling to their ancestral beliefs as a means of preserving their rights. Islam, moreover, refused recognition of ancestral spirits (that could possess individuals and cause madness), classifying them as demons. Therefore it prevented healing recourse to *ndoep* and *samp* rituals and left only access to (frequently charlatan, according to Storper-Perez) marabouts.

If the ascendancy of Islam officially impeded *samp* and *ndoep* rituals, what Collomb called 'traditional healing' was certainly undergoing profound transformations. Nonetheless 'traditional healers' offered by far the majority of mental health care in Senegal in the 1970s.[57] However, taking seriously the thrust of historical change makes it difficult to invest the term 'traditional healer' with a clear meaning. While Collomb was not unaware of historical forces, he did not turn his accomplished intellect to sociologically profile 'traditional healers,' or even to give a clear definition of what he considered a traditional healer, versus for example a 'charlatan.' Indeed, beyond Storper-Perez' relatively obscure book, mental-health researchers in the 1970s were not especially interested in the politics involved in 'inventing tradition.'[58]

In 1974 Collomb joined the efforts of traditional healers to organize a demand for state certification or testament to their status and skill as healers. Collomb envisioned such accreditation leading to their increasing integration into psychiatric services.[59] Collomb's advocacy reflected a broad current in post-colonial medicine concerning the

difficult position of traditional healers in the 1970s, since they had no official status or recognition.[60] In July of 1975 Senegalese legislation, prompted in part by the research of the Fann group, recognized the role of traditional healers in treating mental illness.[61] The Senegalese legislation was re-enforced by the WHO policy of promoting the use of traditional healers to provide primary health care around the globe. First articulated in 1976, this policy was reiterated during the 1978 WHO conference on primary health care in Alma-Ata that recommended that states should rely overtly on traditional healers to bring more health care to rural areas.[62] At the same time, in an effort to minimize costs and maximize availability of care, the WHO aimed to integrate mental health care with primary health care. This policy has been cramped by the strains suffered by healers in working with the WHO and by the difficulties some medical professional have accepting healers.[63] The WHO also commissioned a Beninian doctor who had made his career in Senegal to compile an *Encyclopedia of Traditional Medicine*, thereby encouraging the development of a written, text-based practice out of an oral culture.[64]

The WHO policies gave rise to '*tradipraticiens*' [tradipractioners] who 'invented a tradition' that combined African pharmacopeia with some elements of biomedical science. Collomb commented on this development, 'the new interest of international organizations in African traditional medicine (the WHO, OUA/Organisation de l'unité Africaine, CAMES/Conférence Africaine et Malgache pour l'Enseignement Supérieur) is pushed by the desire of the people to rediscover a cultural identity in the process of decay.'[65] The sociologist Didier Fassin reflected on how this formalization of 'traditional healing' transforms the characteristic charismatic authority of healers into routinized 'status' attested by state certification. To illustrate the sometimes bizarre results of these policies, Fassin recounted a confrontation between a French doctor and the Senegalese head of the Dakar medical faculty. The French doctor, who ran a leprosy clinic using traditional healing methods, accused the Senegalese doctor of excluding her from a conference because of bias against her treatment methods.[66]

Support for traditional healers has grown among other international agencies as well, notably at the World Bank, and the Ford Foundation. The World Bank is currently the umbrella organization for a highly international Indigenous Knowledge Project (the IK project), which aims to integrate various forms of local knowledge, including herbal cures and traditional healing, into mainstream development projects.[67] The Ford Foundation is a major funder of Promotion de la Médécine Traditionelle

(Prometra), an international organization that promotes traditional medicine by organizing healers and supporting patent applications for herbal medicines. Established in 1976, Prometra currently claims 21 member groups, including associations in Senegal, Mali, Benin, Cameroon, Ghana, USA, Uganda, Kenya, Guinea-Bissau, Togo and Burkina Faso. Dr. Erick Gbodossou, the current head of Prometra in Dakar is a former student and collaborator with Collomb; he is the main character in the Fann sponsored film, *Science dans l'ombre* and an adept of Voodoo.[68] Prometra's well-equipped central office occupies a large new building in a Dakar suburb, from which it organizes healers around the country and, indeed, the continent. The international headquarters of Prometra are in Atlanta, Georgia, and are run by a Morehouse Medical School Professor, Dr. Virginia Floyd, who is a former Program Director for the Ford Foundation. There is a self-conscious effort to promote African-American ties to African traditions via Prometra, as demonstrated in the 1996 Coumba Lamba celebrations.[69] Currently they are planning an expansion into Senegal's religious capitol, a move that seems likely to develop ties between the healers and the religious leaders.

The currents of globalization flow in diverse directions: universal psychiatric science and traditional healing are promoted via various agencies and interest groups. Meanwhile professional mental health care in Africa remains drastically under-funded and the integration of cultural sensitivity into biomedical out-patient and hospital care remains incomplete.[70]

Collomb left Fann in 1978 in order to take up a medical position in France. He died suddenly the following year. Collomb's departure from the Fann hospital was accompanied by a sweeping change of personnel, with Senegalese or other African nationals replacing the European researchers, so that the hospital in 1978 embarked on a new, more solidly Senegalese post-colonialism. *Psychopathologie Africaine* continued to be published, still show-casing the latest of African psychiatric research.[71] Yet the African doctors, nurses and care-takers of post-Collomb Fann inhabited a very different professional space than did their European predecessors. The French researchers were labouring under the weight of colonial racism, and trying to approach Senegalese cultures with open, appreciative minds. The Senegalese doctors and nurses face the task of assuming the status of 'scientist' and of embodying the authority of medical science over and against the authority of healers. In this they are working through an Oedipal drama writ large.

The Senegalese doctors and nurses' struggle is akin to the slow triumph of psychiatrists over spiritual authorities in nineteenth-century Europe. In *Console and Classify* Jan Goldstein recreated this history, in which

secular-minded French doctors fought for status and authority against the traditional guardians of the mentally incapacitated, men and women of the Catholic Church.[72] In the case of psychiatry in Senegal, however, there is an ironic component to this epoch-making struggle: the forces of 'science' upon which the doctors rely for power, status and authority, are also (sometimes) advocates of collaboration with traditional priests, magicians, and healers. Imagine if a foundational figure in European psychiatry, such as Jean Marie Charcot, had collaborated with his patients in consulting with a diviner or herbalist about his or her illness. The Fann School under Collomb was not afraid of crossing such boundaries, and purported to draw crucial insights into African psychopathology in the process. African doctors trained in biomedical psychiatry hesitate to do the same.

Collaborating with traditional healers and thereby at least partially abandoning the privileged position of the scientist, incurred a back lash from the Senegalese scientists and health workers, who felt somewhat abandoned by the 'European doctor who turned to native ways.'[73] Africans trained in Western psychiatry are especially vulnerable, since they are acutely aware that they are transgressing into the forbidden preserve of the spirit-world. Only duly initiated healers know how to travel into the spirit world without provoking a possibly deadly assault.

Dr. Babakar Diop was to succeed Collomb as the director of the psychiatric unit. However, shortly after Collomb returned to France in 1978, Diop was struck with an illness that prevented him from working. Many observers, including his family and colleagues at the hospital, considered his ailment to be a spirit possession.[74] Clearly he was paying for his transgression into the terrain of the sacred.[75] But for those African psychiatrists who have not been enfeebled by the spirit world, the science of psychiatry has greater appeal than 'traditional healing.' The current director of the hospital, Momar Gueye, is a staunch defender of biomedicine. While he would not deny his patients recourse to traditional healers, neither does he look toward the spirit world to explain what are for him fundamentally biological problems. He and his colleagues Omar Ndoye and Anne Devos expressed their view, 'the psychiatrist who has studied, and who knows medically what pathology is being presented, will not look for a traditional explanation. Otherwise, why study for 11 years only to return to one's point of departure?'[76] Indeed, this present generation of psychiatrists frequently does not even understand what Collomb meant by tradition.[77]

The crisis of cultural confrontation, acute in West Africa during the colonial era, is now acute in the Metropole. Working with the mental problems of challenged immigrants, practitioners of transcultural

psychiatry provide a significant bridge across cultures and between populations. The dominant transcultural practice in France is led by Tobi Nathan at the Centre Georges Devereux.[78]

Nathan began his ethnopsychiatric therapies in France in 1979; in 1993 he established the Centre Georges Devereux where he brings a veneration for traditional culture to his open group therapy sessions. Some of his major collaborators include Marie-Rose Moro and Serge Lebovici, who in addition to working with immigrants, also provide treatment in humanitarian emergencies.[79] Nathan's practice, however, has not remained above criticism. He is accused of using tradition to the detriment of the individual potential of his patients, and of offering a type of second-rate psycho-therapy.[80]

Marie-Cécile Ortigues continues to work in transcultural psychiatry, and provides therapy philosophically opposed to the Centre Georges Devereux. Working with Mohamed Chabane, Ortigues developed a practice based in respect for the individual's efforts to navigate a successful path between the demands of the contemporary world and the demands of tradition.[81] Chabane and Ortigues' emphasis on the demanding, desiring, or questioning individual prevents their practice from sliding into the objectifying abstractions of ethnic type or national character, while it also gives them purchase against the pull of neo-traditionalism. To shut the patient into a closed cultural system, to grant tradition power over the individual voice, from Chabane and Ortigues' point of view, would be a grave error.

Transcultural practice engages with emergent identities located fully neither in a mythic traditional culture of their homeland nor comfortably in the idiom of twentieth-century French identity. The French post-colonial engagement in transcultural therapies enacts a type of reformulated assimilative and 'civilizing' mission. While the standards and methods of assimilation have changed drastically, the preserve of the moral and historical high ground seems to endure. This dominant trend is complicated by a minor strain of engagement that deliberately seeks the destabilizing of French/Western self, ideas, and perspectives. Reminiscent of Rimbaud's 'j'est autre,' evocative of the split Lacanian self, and perhaps drawn forth via a post-colonial sense of guilt and remorse combined with a genuine desire to engage with the previously taboo African cultures, this minor strain in transcultural psychiatry carries forward a tradition the surrealists thrust onto the historical stage in 1931.[82] The dominant and minor trends, do not separate neatly into distinct practitioners but are present to greater or lesser degree in most transcultural practices.

The restructuring of psychiatry from the colonial era to the era of Senegal's independence has produced this complicated new web of facts, discourses, and power. Neither France nor Senegal are independent players in this new psychiatric arena. Neo-traditionalism is advocated by Nathan in Paris, biomedicine is advocated by the Senegalese director of the Fann hospital, Dr. Momar Gueye. Severing the colonial ties, in the case of psychiatry, has only allowed more complicated international relations and inter-dependencies to take shape. Far from being an obscure concern of a small West African country as appeared possible in the 1960s, transcultural psychiatry is now central to therapeutic practices in France.

## Notes

1. Georges Devereux, *Mohave Ethnopsychiatry and Suicide; The Psychiatric Knowledge and the Psychic Disturbances of an Indian Tribe* (Washington, D.C Government Printing Office: 1961). For comparable work on Senegal see, Andras Zempleni, L'interprétation et la thérapie traditionnelles du désordre mental chez les Wolof et les Lebou (Sénégal), Thèse de 3ème cycle, 1968.
2. Association des Chercheurs Sénégalaise *La Folie au Sénégal* (Dakar, 1997), p. 15 and p. 209.
3. For example, legislation of February 11, 1941, article 74 of the code pénal indigêne, outlawed divination throught the administration of poison, even in cases where the parties consented. Section VIII, article 92, outlawed 'calumnious denunciation' (which would presumably cover accusations of witchcraft), Section VIII, article 105, outlawed sorcerey, magic and 'charlatanism' (which would include some instances of traditional healing), establishing a punishment of 15 days to 6 months imprisonment. See, *La justice indigêne en Afrique occidentale française* (Rufisque; Imprimerie du Haut Commissariat, 1941), pp. 31 and 38–39. Colonial laws were unevenly enforced, and customary law was allowed precedence in many instances. René Pautrat, *La justice locale et la musulmane en A.O.F.* (Rufisque, Imprimerie du Haut Commissariate de la République en Afrique occidentale française, 1957), states that in cases where customary law "deeply shocks our sense of humanity" it could be contravened (p. 92). This would apply, for example, in divination by administration of poison, in accusations of witchcraft, and in cannibalism. Gaston Jean Bouvenet, *Recueil annoté des textes de Droit Pénal applicables en Afrique Occidentale Française* (Paris, Editions de l'Union française, 1955), cites legislation of Sept. 9, 1945, article 8, on the illegal practice of medicine, which became applicable in AOF in 1952 (p. 427); November 19, 1947, law against cannibalism (p. 51).
4. Myron Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914–1945* (Portsmouth, NH; Heinemann: 2002), pp. 161 and 165.
5. Andras Zempleni, "La thérapie traditionnelle des troubles mentaux chez les Wolofs et les Lebou (Sénégal)," *African Therapeutic Systems*, ed. by

Z.A. Ademuwagun, John A.A. Ayoade, Ira Harrison and Dennis M. Warren (Waltham, MA; Crossroads Press, 1979), 144–150. Henri Collomb, "De l'ethnopsychiatrie à la psychiatrie sociale," *Canadian Journal of Psychiatry*, Vol 24:5 (August 1979) 459–470, pp. 464–465.

6. There were, of course, laws against cannibalism, the favourite practice of witches. However, these laws mistook the metaphysical nature of West African cannibalism, which we might best express as a form of soul-theft rather than actual ingestion of flesh and blood. Thus, legal cases were brought against individuals accused of actually eating the bodies of other people, whereas at best, within their own cultural framework, they were guilty of stealing and eating the 'soul' of their prey. For a series of trials in the 1920s see, Robert M. Baum, "Crimes of the Dream World: French Trials of Diola Witches" unpublished paper held at Northwestern University library. See also, William S. Simmons, *Eyes of the Night, Witchcraft among a Senegalese People* (Boston, Little Brown: 1971); Henri Labouret, "La sorcellerie au Soudan Occidental," *Africa* VIII: 4 (October 1935), 462–472; David Ames, "Belief in 'Witches' among the Rural Wolof of the Gambia," *Africa* XXIX: 3 (July 1959), 263–273.
7. For the most authoritative account see, Andras Zempleni, "La dimension therapeutiqe du culte des Rab," *Psychopathologie Africaine* (1966) II; iii, pp. 295–439. See as well the more recent book, Simone Kalis, *Médecine traditionnelle, religion et divination chez les Seereer Siin du Sénégal; la connaissance de la nuit* (Paris; L'Harmattan: 1997).
8. Henri Labouret and Moussa Travélé, "Quelques aspects de la magie africaine; Amulettes et talismans au Soudan Français" *Bulletin du comité d'études historiques et scientifiques* 1927 X: iii–iv, 477–545.
9. Charles Monteil, "La Divination chez les noirs de l'Afrique Occidentale Française," *Bulletin du comité des études historiques et scientifiques* 1931, XIV:i (Jan–Mars) 27–136. See pp. 134–36.
10. Jules Bois, "Étude documentaire sur l'auteur," in Emile Mauchamp, *La sorcellerie au Maroc* (Paris; Dorbon-Ainé: 1911), pp. 11–67, p. 23.
11. P. Mauchamp, "Lettre de M.P. Mauchamp à M. Jules Bois," in Emile Mauchamp, *La sorcellerie au Maroc* (Paris; Dorbon-Ainé: 1911), 1–3, p. 3.
12. Beyond such severe cases, the French doctors' main exposure to Africans with mental illness came through the military, as discussed below.
13. "Or ce nombre doit être assez élevé, surtout dans la circonscription de Loango, et la nécessité s'impose, peut-être au Gabon plus que partout ailleurs, de prendre des mesures de protection à l'égard de cette catégorie de malades indigènes, de les soustraire au régime d'une révoltante barbarie qui leur est imposé par les féticheurs." (Huot quoted in Reboul and Régis, pp. 98–99).
14. Gustave Martin and Ringenbach, "Troubles psychiques dans la maladie du sommeil," *L'Encéphale* (June 10, 1910) V:vi, 625–671 and (August 10, 1910) V:viii, 97–119.
15. Paul Borreil, *Considerations sur l'internement des Aliénés Sénégalais* (Montpellier; G. Firmin, Montane et Sicardi, 1908).
16. Reboul and Régis, pp. 90–93.
17. Antonin Porot & Angelo Hesnard, *L'Expertise mentale militaire* (Paris; Masson & Cie.: 1918); and Antonin Porot & Angelo Hesnard, *Psychiatrie de Guerre;*

*étude clinique*, préface de M. le médecin-inspecteur Simonin (Paris; Felix Alcan: 1919).

18. Emmanuel Régis and Angelo Hesnard,. *Psychoanalyse des névroses et des psychoses, ses applications médicales et extra-médicales* (Paris; F. Alcan: 1914). Also by Hesnard, *Les syndromes névropathiques* (Paris; G. Doin & cie: 1927) and *Freud dans la société d'après guerre* (Geneva; Editions du Mont-Blanc: 1946).
19. Henri Reboul and Emmanuel Régis, "L'assistance des aliénés aux colonies," Rapport au *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXII session, Tunis, 1–7 Avril 1912, Paris, l'Académie de Médecine.
20. Antonin Porot & A. Hesnard, *L'Expertise mentale militaire* (Paris; Masson & Cie.: 1918), p. 46.
21. Colonial psychiatry has by now many historians including Berthelier, Bégué, Collignon (numerous essays), Keller, McCulloch, Sadowsky, Vaughan and others.
22. A. Porot A. Hesnard, *Psychiatrie de Guerre* (Paris, Felix Alcan: 1919), p. 68.
23. For a first person account of the transition from the Ambulance du Cap Manuel to the new facility at Fann see, Jean Rainaut, "Historique de la création du service de neuropsychiatrie de Fann," *Psychopathologie Africaine*, XVII, 1/2/3 (1981), 431–435.
24. Including Porot, Cazanove, Aubin, Planques and others. Gallais was the director of the "service de santé de l'A.O.F." (according to Reboul & Regis, p. 81, note).
25. Letter from Léopold Sédar Senghor written Dec. 6, 1979, reproduced in, *Henri Collomb, Professeur agrégé de médecine, 1913–1979; Son Oeuvre, Son Humanité*, p. 6. Hereafter cited as *Son Oeuvre, Son Humanité*.
26. In addition to faculty salaries, the costs of construction and physical up-keep of the university were part of the French budget. See, Michael Crowder, *Senegal; A Study of French Assimilation Policy* (London; Methuen & Co., 1962, revised edition 1967), p. 118.
27. On the general question of who funded whose research, René Collignon (interviewed June 12, 2003) says that was very variable. He was with the CNRS as was Andras Zempleni. Edmond Ortigues was on the faculty, like Collomb. MC Ortigues was a student. She applied to the CNRS but was not accepted and pursued her career primarily as a psychoanalyst in private practice (although she also continued to publish). Jaqueline Rabain was CNRS. After the mid-1970s the Senegalese state took over more of the budget, which drew in more diverse funders such as the WHO, the United Nations UNESCO, European countries other than France and some humanitarian organizations (whether religious or of the NGO variety).
28. *Son Oeuvre, Son Humanité*, Préface par Paul Bournay, Private publication in Valbonnais, not available for public sale. Published on the occasion of Dr. Collomb's death in 1979, p. 4.
29. Letter from Léopold Sédar Senghor in *Son Oeuvre, Son Humanité*, p. 4.
30. Ibid.
31. Jacqueline Rabain, *L'enfant du lignage; du sevrage à la classe d'âge* (Paris, Payot: 1979), new edition, 1994.

32. For a complete listing of the scholarship during the early Fann years see, René Collignon, “Vingt ans de travaux à la clinique psychiatrique de Fann-Dakar,” *Psychopathologie africaine* (1978) XIV: 2–3, 133–356.
33. Eric Gbodossou, *The African Concept: From God to Man; An Introduction to African Spiritualism* (Dakar, Senegal; Prometra: 2004).
34. Rainaut, Jean, ‘Historique de la création du service de neuropsychiatrie de Fann’, *Psychopathologie Africaine*, XVII, 1981, p. 431.
35. Dr. Colonel Cazanove, “Les Conceptions Magico-Religieuses des Indigènes de l’Afrique Occidentale Française,” *Les Grandes Endémies Tropicales* (1933), 5: 38–48. Henri Aubin, “L’Assistance psychiatrique indigène aux colonies,” *Congrès des Médecins Aliénistes et Neurologistes de France et des Pays de Langue Française*, XLII (April 6–11, 1938), 147–176. Aubin (1939). Introduction a l’étude de la psychiatrie chez les noirs, *Annales Médico-Psychologiques* I: 1 January, 1–29; Aubin “Discussion du Rapport de Psychiatrie,” *Congres des Médecins Alienistes et Neurologistes de France* (1956) LIV session, 162–165.
36. Aubin, “L’Assistance psychiatrique indigène aux colonies,” p. 164.
37. See, Marcel Griaule,*Conseiller de l’Union Française* (Paris, Nouvelles Éditions Latines: 1957), p. 91.
38. By the 1950s psychological testing rose to prominence in West Africa, with specific accommodation made for cultural and environmental differences among test populations. Collomb participated in at least one study of cross-cultural use of a projective personality test. See, Alice Bullard, “The Critical Impact of Frantz Fanon and Henri Collomb; Race, Gender and Personality Testing of North and West Africans” *The Journal for the History of Behavioral Sciences* 41(3) Summer 2005, 225–248.
39. Thomas Lambo, *African traditional beliefs: concepts of health and medical practice* (Ibadan: Ibadan University Press, 1963).
40. Roger Bastide, “Psychiatrie, Ethnographie et Sociologie; Les maladies mentales et le Noir brésilien,” in *Desordres mentaux et santé mentale en Afrique au Sud du Sahara, Reunion CCTA/CSA – FMSM – OMS de Specialistes sur la Santé Mentale* (CSA, 1958), 223–232, p. 227. See also Jean Rauch’s study of the prophet Albert Atcho, “Introduction à l’étude de la communauté de Bregbo,” *Journal de la société des Africanistes* (1963) XXXIII:i, 129–202.
41. See the “Report and Recommendations” from the 1958 Bukavu conference (sponsored by the CSA/CCTA [Scientific Council for Africa South of the Sahara/Commission for Technical Co-operation in Africa South of the Sahara], WFMH & WHO) issued in London, April 14, 1958, p. 9.
42. See the Introduction to Giovanni de Girolamo, Leon Eisenberg, Sir David P. Goldberg and John E. Cooper, eds, *Promoting Mental Health Internationally* in honour of Professor Norman Sartorius, London: Gaskell: 1999. For a critical perspective on the WHO project see, Arthur Kleinman, “Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness,” *British Journal of Psychiatry* 151, 447–454.
43. The DSM-III was first published in 1980; the ICD 10 was published as, The *International classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (Geneva; World Health Organization: 1992). See, A. Jablensky, “Beyond ICD-10 and DSM-IV: Issues in Contemporary Psychiatry,” in Giovanni de Girolamo, Leon Eisenberg, Sir David P. Goldberg and John E. Cooper, eds, *Promoting Mental Health Internationally* in honour

of Professor Norman Sartorius, London: Gaskell: 1999, pp. 47–56. On the DSM-III, Stuart A. Kirk and Herb Kutchin,*The Selling of DSM: The Rhetoric of Science in Psychiatry* (Aldine de Gruyter: 1992), gives a detailed account of the origins of the DSM-III and the sweeping transformation of psychiatry it represented.

44. Collomb continued, "Mais il y a un domaine qui demande à être exploité, même par les plus matérialistes scientifiques, c'est le domaine de la parapsychologie ..." *Son Oeuvre, Son humanité*, p. 26.
45. Henri Collomb, "De l'ethnopsychiatrie à la psychiatrie sociale," *Canadian Journal of Psychiatry*, 24:5 (August 1979), 459–470, p. 460.
46. Henri Collomb, "L'avenir de la psychiatrie en Afrique," *Psychopathologie Africaine*, 1973, IX: 3, 343–370. Hereafter cited as Collomb, "Avenir."
47. Collomb, "Avenir," p. 347.
48. This sounds much like George Devereux's project.
49. Collomb, "Avenir," p. 348.
50. Marie-Cécile and Edmond Ortigues, *L'Oedipe Africain*, 3rd edition (Paris, Harmattan: 1984), relied on the hundreds of clients Marie-Cécile Ortigues treated at Fann. For an assessment of the legacy of this book see, Alice Bullard, "*L'Oedipe Africain*, a Retrospective," *Transcultural Psychiatry*, 42: 2 (June 2005), 171–203.
51. See, for example, Edmond Doutté, *Magie et Religion dans l'Afrique du Nord* (Alger, Adolphe Jourdan: 1908).
52. Interview with Marie Cécile and Edmond Ortigues, Paris, June 2003.
53. Collignon, "Prend toute sa place aussi dans ce mouvement, le désaveu de certains errements passés qui avaient fait tolérer une présence ambigue de guérisseurs au sein du service en dépit des enseignements des recherches ethnologiques sur les fondements de l'efficacité du guérisseur dans son espace propre qui ne saurait etre réduit à celui d'une situation de dépendance paramédicale." René Collignon, "Santé mentale entre psychiatrie contemporaine et pratique traditionnelle (Le cas du Sénégal)," *Psych Af*, 2000, XXX: 3, 283–298, p. 294.
54. Marie-Cécile and Edmond Ortigues *L'Oedipe Africain* (Paris, Harmattan: 1984), p. 155.
55. Danielle Storper-Perez, *La folie colonisé* (Paris; F. Maspero: 1974).
56. Storper-Perez, p. 66.
57. Collomb, "Avenir," p. 353. See also, Henri Collomb, "Recontre de deux systèmes de soins" *Soc Sci Med*, VII (1975), 623–633; Henri Collomb, "Psychiatrie moderne et thérapeutiques traditionnelles" *Ethiopiques* 2 (1974), 40–54; and Pascal Picard, "Reflexions su le phénomène de la double demande." Dakar: faculté de médecine, 170 pp, Mémoire de CES psychiatrie, 1985, p. 30.
58. Terence Ranger and Eric Hobsbawm provided scholars with a much needed critical edge with their *The Invention of Tradition* (New York; Cambridge University Press: 1983).
59. Collomb, "Avenir," p. 356.
60. For a sense of the era see, the collection of essays in Z.A. Ademuwagun, John A.A. Ayoade, Ira Harrison and Dennis M. Warren, *African Therapeutic Systems* (Waltham MA; Crossroads Press: 1979).

61. Law 75–80, July 9, 1975. See, René Collignon, "Santé mentale entre psychiatrie contemporaine et pratique traditionnelle (Le cas du Sénégal)," *Psych Af*, 2000, XXX: 3, 283–298. Hereafter cited as Collignon, "Santé mentale."
62. Collignon, "Santé mentale," pp. 291–292.
63. Gilles Bibeau, "Regards Anthropologiques sur une Encyclique Sanitaire peu Orthodoxe de l'OMS," *Psychopathologie Africaine*, XIX(2), 1983, 231–238; and Koumare, B., Coudray, J.-P., Miquel-Garcia, E.; "L'Assistance psychiatrique au Mali; à propos du placement des patients psychiatriques chroniques auprès de tradipraticiens." *Psychopathologie Africaine,* XXIV(2), 1992, 135–148.
64. Didier Fassin discusses this project, though without naming the doctor or specifying if the project came to fruition, in *Les Enjeux politiques de la santé*, pp. 90–91. It is possible Erick Gbodossou, the current head of Promotion de la Medecine Traditionnelle (Prometra) in Dakar and a former student and collaborator with Collomb was the researcher of the encylopedia.
65. He continued, "the current situation is very ambiguous, as demonstrated in a recent study (Ph. Singer: 1976)." Henri Collomb, "De l'ethnopsychiatrie à la psychiatrie sociale," *Canadian Journal of Psychiatry*, Vol, 24: 5 (August 1979) 459–470, p. 459.
66. This confrontation played out in the press, *Le Soleil*, 24–25 Jan. 1986. See Fassin, *Les enjeux*, p. 93.
67. The IK notes are published by the World Bank and have now been compiled in book and CD format as, *Indigenous Knowledge; Local Pathways to Global Development, Marking Five Years of the World Bank Indigenous Knowledge for Development Program* (World Bank, Africa Region; Washington, D.C.: 2004).
68. In Senegal, Prometra publishes the magazine, *Médécine verte*.
69. See, http://www.prometra.org/FrenchWebsite/French_Coumba_Lamba_Project.html.
70. Ellen Corin, Uchoa, E., Bibeau, G., Koumare, B., Coulibaly, B., Coulibaly, M., Mounkoro, P. & Sissoko, M., "La Place de la Culture dans la Psychiatrie Africaine d'Aujourd'hui," *Psychopathologie Africaine,* XXIV (2), 1992, 149–181; and Ndoye, O., Devos, A., Gueye, M., "L'ethnopsychiatrie à Fann aujourd'hui," *Psychopathologie Africaine*, XXX(3), 2000, 265–282.
71. Indeed, *Psychopathologie Africain* has outlived its Nigerian counterpart, *The African Journal of Psychiatry* (1976–1981) by a good many years.
72. Jan Goldstein, *Console and Classify; The French Psychiatric Profession in the Nineteenth Century* (New York, Cambridge University Press, 1987).
73. The nurse René Leuckx, who spent 7 months at Kénia in 1977, criticized the arrangement as one that threw the nurses too much onto their own resources, denying them and the patients interaction with doctors. See, René Collignon, "Santé mentale entre psychiatrie contemporaine et pratique traditionnelle, (Le cas du Sénégal), "*Psych Af*, 2000, XXX: 3, 283–298, p. 286.
74. Personal conversation with Gilles Bibeau, June 2003.
75. Momar Gueye, as quoted in Colligon, "Santé mentale," *Psych Af.*, XXX: 3, p. 291.
76. Omar Ndoye, Anne Devos, Momar Gueye, "L'ethnopsychiatrie à Fann aujourd'hui," *Psych. Af.* 2000, XXX: 3, 265–282, p. 276. See also, René Collignon, "Santé mentale entre psychiatrie contemporaine et pratique traditionelle (le cas du Sénégal)," *Psychopathologie Africaine*, XXX: 3 (2000), 283–298, 291.

77. Ibid.
78. Tobie Nathan, *L'influence qui guérit* (Paris: Editions Odile Jacob: 1994); Tobie Nathan and Isabelle Stengers, *Médecins et sorciers* (Le Plessis Synthélabo: 1995).
79. For example see, Marie Rose Moro, avant propos by Serge Lebovici, *Parents en exil; psychopathologie et migrations* (PUF 1994); *Enfants d'ici venus d'ailleurs: naître et grandir en France* (Paris, Découverte: 2002).
80. It is certainly possible to look on Nathan's work with a critical eye. See, Jean-Godefroy Bidima, "Ethnopsychiatry and its Reverses: Telling the Fragility of the Other," *Diogenes* No. 189, Vol. 48:1 (2000) 68–82. *Transcultural Psychiatry* 34:3 published three articles on Nathan, two positive and one rather critical especially of Nathan's recent neo-traditionalism.
81. Mohamed Chabane and Marie-Cécile Ortigues, "Enfants africains et maghrébins; entre les incitations à la réussite individuelle et la fidélité aux valeurs de leurs traditions," *Psychiatres* (1995) 107, 29–37, p. 37.
82. Consider Yves Kaufmant & his GRAPPAF series published with Harmattan. GRAPPAF stands for Groupe de Recherche et d'application des Concepts Psychanalytique à la Psychiatrie en Afrique Francophone. Henri Aubin, one of the prominent French psychiatrists of colonial West Africa, took time out from his writings on denial and magic to write an essay on Rimbaud, "Le Cas Rimbaud," *Evolution Psychiatrique* (1955), pp. 329–347.

# 10

# Madness, Vice and Tabanka: Post-colonial Residues in Trinidadian Conceptualisations of Mental Illness[1]

*Roland Littlewood*

How directly relevant was clinical psychiatry to imperialism? Both evidently developed in the same period. They shared certain modes of reasoning. We might note, for instance, affinities between the scientific objectification of illness experience as disease and the objectification of people as chattel slaves or colonial manpower;[2] both argued for an absence of 'higher' functions or sense of personal responsibility among patients and non-Europeans. The extent, however, to which an elaborated set of ideas which might be termed 'imperial psychiatry' provided a rationale for colonialism in British Africa or India[3] is debatable: in recent reviews I have argued that the evidence is fairly meagre. With remarkably few exceptions,[4] the small number of colonial psychiatrists barely participated in the theoretical debates of early cultural psychiatry: segregated facilities, of course;[5] prejudice and neglect, undoubtedly; but hardly practicable ideologies for racial or cultural inferiority.

One possible exception was the common assumption in the 1940s that too rapid social change (that is access to schools and wage labour) were causing an increase in African psychiatric illness.[6] Whether this was taken seriously in London I am doubtful; it could of course be turned on its head by arguing that it was colonisation not 'change' that was pathogenic.[7] Whilst the few colonial psychiatrists were quite tangential to the making of Colonial Office policy (and were themselves rather 'marginal' individuals within British or colonial society)[8] in the francophone colonies and in Haiti, local psychiatrists developed radical critiques of European domination to argue for a distinct 'African identity' as against the settlers.[9] Why the English–French difference?:

perhaps because French colonialism favoured a model of cultural and biological assimilation, the English arguing for segregation.[10] French psychiatry was a much more 'intellectual' profession than its British equivalent, and medical students from Martinique or Senegal when studying in Paris were more likely to be exposed to political debate than they would have been in a London medical school. Ethnographers like Rivers and Malinowski, aspects of whose work developed into what was to become medical anthropology, whilst they relied on missionary evidence and colonial office support, did not significantly influence British policy on Africa or elsewhere.[11] If colonial diseases were of any political interest to the metropolis, the concern was not about madness but the acute infections which threatened to deprive the administration of its labour force,[12] or the psychological health of the Europeans themselves.[13]

The United States model of psychiatry and racism is hardly appropriate here. The nineteenth-century Southern American medical arguments on diseases such as *drapetomania* (the impulse of the slave to escape),[14] or even, as argued by Benjamin Rush in 1799 that African ancestry was itself an attenuated disease, became necessary for White supremacy only after Emancipation threatened.[15] Among Native Americans, for whom collective political action was impossible after they were dispersed on reservations, twentieth-century administrators and medical officers developed increasingly psychological – and thence psychopathological – explanations to explain their high rates of suicide, alcoholism and general failure to participate in national life. But the prominence of medical arguments in the American slavery–Emancipation debates were not matched in the British Empire, perhaps because of less settler power[16] and also the relatively short period of time between the advent of independence movements and actual decolonisation.

Perhaps more appropriate evidence can be produced by looking at continuing Caribbean popular attitudes to mental illness and the mentally ill, as reflected in local notions of illness itself. My data here is drawn from Trinidad in the 1980s and 1990s but I think it is not atypical of attitudes and responses elsewhere in the West Indies,[17] and maybe more widely in the post-imperial countries.

## Madness

Madness is locally called *folie* in French Creole and is also variously known as *crazy*, *offkey*, *off the head*, *going off*, *loco*, *kinky*, *head ai' right*, *ai'*

*right dey, ai' collective*. It is recognised through continued unintelligible behaviour which is quite meaningless:

> They would do something opposite to your sense: so we style them mad people. Something unusual in madness but they selves ai' know they mad. They climb a pole; go in water; they feel they bathe when it have sun; they out of memory – they don't know what they do; they just pick up a cutlass and chop someone, or pick up a baby and dash them in road; cuss, lie down in the centre of the road; always do strange things other don't do; take he clothes and burn it up; burn house; launch boat an do out by heself.

Other mad actions commonly cited are eating plantain skin, garbage and raw food; walking around naked; touching people who pass; walking in the hot sun in the middle of the road; staring at the sun or the stars; failing to recognise people; refusing to comb one's hair; bathe or accept the help of others. One villager I knew had been in St Ann's, the psychiatric hospital in Port-of-Spain, for many years. He was discharged home to be visited at intervals by a nurse for regular injections. Any initial sympathy for Thomas on his return was rapidly forfeited by his ungracious behaviour. His brother built him a small wooden house on family land 'but he just mash it down'. When I was in the village, he had stripped his hut of its walls for firewood for cooking, and it consisted of a leaky roof, the house posts and some floorboards. He is given old clothes at intervals but cannot always be persuaded to wear them. Thomas is seldom seen in the village, usually disappearing into the nearby bush or greeting any passerby with surly and unintelligible mutters.

The madman is described as loud, boisterous, erratic and potentially explosive. His most frequently mentioned characteristic is his violence: 'They just do anything that get in their way'. Stories circulate in Trinidad about the dangers of St Ann's and I repeatedly heard one about 'this madman a few years back take a knife and stab the boy in the next bed'. Other patterns of behaviour may superficially resemble madness: 'A child behave as if it mad but it ai' mad'. The confusion of the madman is to be distinguished from that of becoming *bazody* (dizzy), for instance in the crowds of Port-of-Spain, particularly during Carnival; or when one has frights or continued worries as when 'you don' know what you' wife doing'; or after a blow on the head. The bazody person soon recovers and the state, although it may be associated briefly with bizarre behaviour, is always intelligible through the immediate precipitants. Drunkenness is also akin to madness for 'When you runs a drunk you do similar things,

you part mad'. The drunkard however can always be distinguished by his staggering gait and slurred speech: 'The mad must walk straight, they just do funny things. He has a different expression on his face – he look kind of wild. Mad person's eyes got wide and staring you, staring you; if they sit down nice, all of a sudden they want to make a sudden grip.' The madman is best avoided unless they are a relative or an old friend. Talking to him is not going to help anything. Nor will he be grateful for anything you might do to help so, as you may get hurt, 'pass by a next way.' He is living in a private world of his own: 'They laugh so, just by themselves. Tell them howdy and they ai' tell you. If you carry on a conversation, they on a different [one]'. Madmen say things which are manifestly not true: 'These imaginations they put on a real side. From the time it reality, you sick'.

When a villager meets Thomas, 'Thomas pass by me and he say "Right!" [the customary short greeting] and I say "Right!" but I don't go near. I keep to myself'. Madness is hardly catching – 'though some say it do rub off' – but it always carries a potential for physical aggression. If violence occurs, the police are asked to take the madman, sometimes via a magistrate, to the mental hospital. If he is feared it is for reasons of personal safety, not because of any ultra-human influences. Pinnacle villagers maintain a robust attitude to the mystical, and Annette, an elderly widow who is half-seriously regarded as a *soucouyant* (vampire), is not publicly shunned, far less accused, although she has significantly few intimate friends.

If they do not appear violent, mad people are often treated with derision, and the nurses at St Ann's say many of their ex-patients carry a cutlass or stick to protect themselves. The assumption of violence can be used by madmen to obtain food; a patient in the hospital told me that he used to go round town saying 'I from St Ann's, I'll kill you' in a sometimes successful attempt to get food. For the madman, St Ann's is indeed a refuge from living in the streets, and staff are frequently called to see an old patient who is threatening the police: 'If you ai' take me in I gone lick you. I have my permit for St Ann's [i.e. a previous admission]'.

The madman is described as characteristically male. His attributes – poverty, disorder, semi-nudity, his preference for the bush as opposed to the house, his arbitrary actions and his potential for violence – all recall the image which respectable people offer of the *worthless* working-class man. Lawrence Fisher has noted an extraordinary salience of the madman in West Indian calypsos, tales, gossip and literature, and comments that he offers an ironical, and ultimately hopeless, internalised image, one rooted in the identity which the White has ascribed to

the Black, the epitome of worthlessness.[18] The image of the madman recalls the popular perception of the Rasta: indeed, for many middle-class West Indians, the Rasta is dismissed as 'mad'. If Rastafari can be taken as an assertion of those informal *worthless* characteristics which Whites have ascribed historically to Blacks, it is not surprising that many of the younger psychiatric patients in St Ann's have adopted dreadlocks and Rasta idiom. The adoption of Rastafari by the madman actively reappropriates a devalued identity.[19]

Whatever its origin, madness in Trinidad is generally referred to as an all or nothing condition, total and effectively untreatable: 'Once mad always mad'. Some argue that the brain is physically altered, others just that the mind is 'taken over': what is actually happening inside one's body when one is mad remains mysterious and of little interest. But all agree that the madman must be taken to St Ann's by the police. This is for public safety, not for treatment, as there is nothing the doctors can do. Madness induced by a spirit, the most commonly cited cause, cannot be removed without God's rare intercession. In conversation, madness is usually ascribed a discrete external cause; even informants who advocate the 'pass down in family' theory feel that the affected individual needs more than a predisposition. In practice, when dealing with local instances, a more complex set of explanations is offered by villagers which do link madness to individual personality and everyday life. Madness in a friend or relative may be the consequence of *studiation*, of receiving bad news, of *pressure*, *grinding* and *tabanka*, or of the pursuit of *vices*. It is in these particular experiences that we find a path from everyday life to madness which implicates an internalised set of mental attitudes or psychological processes, both historically noted.

*Studiation* refers to not only the study of high science (European magic or sorcery) but also to any undesirable habit ('they study meanness and commonness') or to excessive mental emphasis or opinion on any subject, especially when acquired through reading: 'You overpower with pressure of study. We have young people at school an' they can' take it a next time. You overlearn an' you brain too light, it worry you head'. Studiation madness is rather different from the otherwise undifferentiated picture of madness: it is recognised through social withdrawal (becoming *selfish*), aloofness, emotional distance and ultimately total self-absorption. Some villagers in any village felt that the Europeans – cold, supercilious and self-centred – have become like that through their books: the White temperament is, as it were, studiation madness spread out thin. Theological speculation when reading

the Bible, a common village interest, is particularly dangerous: 'scripture hell of a thing, it send you mad'. Excessive study of any type may be described as *travelling*, lost in a personal world, out of touch with reality, the word used to describe the experience of spiritual Baptist mourning. Studiation has a morally as well as a practically ambiguous connotation, as if, like high science, it somehow involved unhallowed domains; certainly book study is not regarded highly, for it involves leaving the community for self-betterment, a denial of local solidarity. Those families who encourage their children to leave Pinnacle to continue their education – and who take on the whole respectable package of restricted public drinking, sobriety, hard work, saving, church attendance, reading the weekly *Catholic News*, not going *bare back* if they are men and not wearing trousers if women – are accused of being *social* (pretentious).

*Studiation* is not only an intense concentration on books but preoccupation with anything, particularly worries or slights which cannot be resolved. The breaking of bad news too harshly or too suddenly may precipitate madness by causing overwhelming *pressure* (sudden worry). It is sometimes likened to a blow on the head: 'That could worry you' head, even send you crazy a time. It have a woman in Blanchisseuse an' they come an' say she man drown off Tobago an' she bawl and carry on an' she crazy for truth. They take she up to the mental'. But such madness is usually short-lived: 'If you frighten, blood fly to you head but you ai' mad all time. If you get good care it stop, it don't even last a week on you. They put ice on your head I hear but I ai' sure'.

## Gender and class

African-Caribbeans have been described as living by and generating two opposed local sentiments.[20] An egalitarian working-class and male-orientated ethic of personal *reputation* is recognised and contrasted with *respectability* which is associated with church marriage, middle-class and White ideals, with education, social hierarchy and chastity; and which is represented most typically in women. *Reputation* (or *worthless behaviour* as it is usually known in the Trinidad village) is represented in the footloose 'circumstance-orientated' man, pragmatic and egalitarian, drinking in the rum shop and pursuing indiscriminate sexual adventures. As the calypsonian Sparrow sings:

Because a woman is a woman for me
Ah don't care how she ugly and obzocky
I'm a busy man wid no time to lose
Ah don't pass my hand, ah don't pick and choose
So any kind o' woman, one foot or one hand
Dey cannot escape from me, Mr. Rake-and Scrape[21]

It has been argued that *respectability* is the local justification of economic stratification in terms of personal moral choice, reflecting the colonial and post-colonial structurings of class and colour; *reputation* is the behavioural response to this, an active affirmation of the ascribed working-class and 'Black' characteristics. Both sexes are said to move up towards respectability as they get older, wealthier or if they marry lighter-skinned partners. It is a fragile and often illusive goal rather than a norm, and one which is frequently contested; less an abstract ethic than the workings of relative economic power, formalised in their justification. For the man, marriage is a move away from 'circumstance-orientated' reputation towards *tibourg* (petit bourgeois) respectability; its economic obligations may be assumed reluctantly for 'Why buy cow when I get milk free?'

Recognition of respectability is not only precarious, usually dependent on an adequate income, but also on who is doing the perceiving, and when. For everyone is critical of another's self-advancement and is always alert to hypocrisy and failure: 'The higher monkey climb the more he expose himself'. The pregnancy of Julia, the rather reserved daughter of a fisherman but now one of the village teachers, and who had been unwisely *friending* with a married policeman, was the occasion for unconcealed delight in the village rum shops, for, seen from 'below', the monkey's exposure is determined by the higher standards imposed as you move up: the risks of failure are greater and the fall longer. To adopt the signs of *good training* (frequent church attendance, continued parental control over children, straightened hair, 'good English' and an apparent ignorance of patois, or an affectation of superiority) too soon or without possessing a reliable income, is pretentious – to be social or *béké nègre* (White Black). Peter Wilson described this sentiment of solidarity with an ironic local expression from the island of Providencia – 'crab antics': as crabs try to climb up out of a crab barrel they are pulled down by others so the top of the barrel can be safely left off, while the single crab in an open barrel escapes. This, particularly male, value is articulated in an extensive local repertoire of *picong* (satire) represented nationally in the calypsos which offer a lower class viewpoint, or a Black viewpoint, or a male viewpoint.

## Tabanka

There is a particular cause of madness which articulates this dichotomy of respectability–reputation, and the post-colonial baggage it carries. One form of grinding (worry) has a specific name. *Tabanka* occurs 'when you' wife left you and you take it on, keep study it', especially when deserted for another man. It is said to be most common among those formally married in church and among the aspiring *tibourgs* (nurses, midwives and teachers) and *békés nègres* (who pretend to White and middle-class values and life-style). It is characterised by a 'heavy heart', by lassitude, loss of appetite, stomach cramps, insomnia and loss of interest in work or social life. The tabanked male wanders about or remains alone at home, continually turning over in his mind thoughts of the faithless one:

> 'They don't do anything to pass off studiation, they drink, they smoke, they ai' eat, often they ai' coming home. They concentrate on how they was before. You broken down: it does take an effect on your body also; from brain to body; according as the brain function the body deteriorate to an extent; you not eating, you not drinking, you not sleeping, everywhere you turn you thinking'.

Similar experiences are recognised in a lesser degree as part of the fluctuation of everyday mood, but tabanka is a discrete state with very specific consequences. The word may refer to other losses but is then less severe and only used with the primary sense, sexual desertion, still in mind: 'Love is the first thing. It must damage your love. If someone rob your house you don't take it on so'.

The consequences of tabanka can include death from accidents whilst drunk or the loss of work. 'You drink to keep off studies. It act on the brain: you drink it out, you cast it out, you taking away thoughts'. If unresolved it can lead to murder or suicide: 'It happen to nearly every man in Trinidad, the most thing. You hear man poison self? It tabanka. A man hang on tree? It tabanka. One of the greatest [most common, most significant] things in Trinidad'. It can progress to madness and some villagers say there is a special ward for it in St Ann's Hospital. 'It have this boy die through grief. He die in mental. He quiet, you take food into the house and he throw it away'. Thomas had been 'mad once but that wear out from him, then the girl leave him and he get crazy again'.

'Once you take it on you get tabanka. If you don't take it on you ai' get tabanka. The man who really loves, it worse damage'. It is more serious

if the couple have been *church married* rather than just living together because this includes economic as well as emotional investment:

> 'If it your girlfriend you shrug it off – in three days you halfway to a next! ... [But] he love his wife, he have all his trust in she, he give she all his money and she go and leave him and he remain blank; you love your love and you love your money. It comes double degrees'.

Another male villager added 'It ai' the loss of her, but what you've given her'. Indeed, while men may talk in front of women of tabanka as a romantic tragedy, they always emphasise the financial loss. Women are typically rather contemptuous of men with tabanka: 'Men take it on so! They tell you leave but, if you does, they craziness itself!' Even men admit that tabanka is a sign of weakness: 'Some don't get it because they have a strong heart. It all depends on personal feelings. You shouldn't get tabanka. However you take it, someday you and that person got to part, so why the harass?' Tabanka characteristically occurs only after an economic relationship has been established between a man and a woman. It is not *amour fou* or *lovestruckness*, the pursuit of a hopeless and never consummated attachment.

Women pride themselves on being less likely to experience tabanka, for they already expect men to be unreliable. Both sexes regard women as made of sterner stuff. As the principal source of cash, men argue that they are more responsible, and thus more vulnerable: 'You studying your two ends meet an' your wife not studying. Women more on a side. They can take a love here and take another tomorrow. Men find it more difficult. If women get tabanka they recover themselves faster'.

The acknowledgement of tabanka is necessarily private, for its public recognition provokes barbed jests and humiliation. The very mention of the word is greeted by men and women alike with mirth, if not derision. Its resolution involves the victim being encouraged by other men, usually close friends, to turn his mind to other interests. They counsel modest self-control, to forget the faithless one, not to attempt retrieving his situation, nor to seek revenge, but instead to make fresh attachments. The hilarity of tabanka lies not in any contravention of acceptable behaviour (indeed it is almost regarded as inevitable) but in the infatuation of the deserted man.

Moving around the country for work may enable the man with a reasonable income to support an *outside wife* (or *deputy*). If he manages it discretely, avoiding scandal, and adequately supports all his children,

his reputation can be enhanced with little cost to his respectability. Men are expected to provide for their children, even if the mother is friending or living with another man. Recognised paternity, but not virginity, is of importance and a woman is shamed by not having an identified father for her children. An unmarried man who supports another man's children may be ridiculed and the new-born child's physiognomy is carefully scrutinised, assisted by a complex local classification of 'colour'. In the picong of calypso:

(a) I black like jet and she just like tarbaby
Chinese children calling me Daddy
(b) An Indian couple up Belmont
Make a white baby I'm sure you heard the stunt
What a loving father
He said his wife was drinking milk of magnesia

A woman is expected to have sex only with the man who is giving her money if they are living or married. The possibility that she is not is a constant preoccupation of men: 'Someone's been putting pepper in your rice'; 'There's more in the mortar beside the pestle' or 'Man trespassing on my land'. Younger and more attractive women may get by economically as a *jagomet* (or *jook about*, poke about), offering favours to a limited number of male friends in exchange for gifts but it is not acceptable for a woman when married or living to have other partners, and a man is not recognised as becoming truly tabanked in a jagomet or friending relationship, unlike marriage:

Since I married Dorothy
She have me going crazy
Horn like fire
I can't take it no longer
You know I nearly dead with tabanka[22]

Sexual access to the woman is exchanged for cash, labour or other services. From the man's point of view:

(a) Not another cent you wouldn't get until you hand up
I'm a big man and dis thing must stop
(b) Now you playing smart . . .
Nobody yet never take me money
And making old style on me[23]

While from the woman's:

(a) Johnny, you'll be the only one I'm dreaming of
You're my turtle dove, but no money no love
(b) The man could be as ugly as sin
But the money is damn good looking[24]

With tabanka, a man is caught short, without either reputation or respectability. His mistake is infatuation with wife and with White values, a failure to perceive his real interests and maintain his autonomy. The older man who accepts the infidelity of his younger wife is despised as doltish for he has completely lost his power of judgement. By contrast tabanka is an indignity which can be successfully transcended. A woman seems less likely to be tabanked because she has not sacrificed reputation to attain a precarious respectability, and by common consent she can only expect to be provided for: only the most worthless of men fails to support his children and she is regarded as well rid of such a partner.

To ask why the very mention of tabanka is so funny is to be met with redoubled laughter and rather uncertain explanations: 'Man has every chance – then he go and lose woman and he come and say he tabanked!' Picong about tabanka expresses the value of egalitarian 'circumstance-orientated' relationships; the notion of 'adultery', the moral conceptualisation of the act of desertion, is restricted to respectable settings such as the church. Lowenthal observes of Afro-Caribbean societies that: 'knowledge of one another's private shortcomings leads people to discredit any claim or pretensions to an unrelenting moral uprighteousness . . . In the West Indies generally personalism usually overrides divisive moral imperatives'.[25]

The mockery of tabanka is less an outright objection to White and middle-class church marriage and supposed fidelity than of surface adherence to their forms when they cannot be economically supported. It ridicules the masquerade of respectable behaviour and reaffirms the tyranny of individual desire and happenstance in the face of pretence. Arthur, a respectable older man, remarked to me: 'They know where it come from. It is a joke to see a man or woman being tabanked'.

## Vices and 'weak'madness

We can gloss *vice* as 'addiction' which leads to madness: a fixed pattern of activity, initially chosen freely by people because it is pleasurable although it may be harmful to themselves or others, and which becomes

increasingly difficult to resist until it dominates and eventually destroys them, no longer an object of choice but a part of their being (Littlewood 1988).

*Thieving* is a vice which becomes impossible to stop when a victim solicits God's justice by lighting a candle on you. God may himself intervene independently with similar consequences, but some suggest that just stealing by itself has an effect on the thief, compelling him to engage in it with fewer and fewer precautions against detection until he *get spoil* – he is caught or becomes mad: 'Their hand fast, they can' see without taking'. A compulsion to repeat stereotyped acts is also found in the vices of high science and obeah when, eventually, a spirit one has conjured up returns, or else God decides that enough is enough. Sexual activities which are vices and which may end in madness include male and female homosexuality; sodomy with people or animals; or sexual relations within the prohibited limits of affinity.

Any unreasonable, unintelligible or angry act may be credited as 'mad' without implying that it is 'really mad'. Villagers distinguish between what I call 'weak' and 'strong' uses of the term. Any known individual acting in a stupid, inappropriate or eccentric way may be called *mad* (or *light-headed*, *doltish*) without suggesting they are really insane. When there is any doubt the terms *mad for truth*, *mad like hell* or *madmad* are used. Eccentricity or behaviour out of character may be a *little way mad* but never *madmad* unless it leads to violence or is quite unintelligible:

(a) Tante Claudette mad. She always talk to herself. She can't hear any other noise at all! She talk like foreign language, I don't know how she do it. Tante talk Spanish, Patois, Congo, she call the names.
(b) 'My uncle mad once. He was to stand for compère (godfather) to my sister and he just go and drop his suit in latrine! He climb up house without a ladder. That crazy. They tie him with rope and pull him down'.

In neither of these cases did anyone else regard their relative as 'really mad'. In a similar use, the back of the van owned by a rather nervous driver from Sangre Grande proclaims 'LUNATIC KEEP OFF'. A well-known Calypso singer carried the name 'Crazy' and acted up to it by outlandish behaviour and costume; he probably derived it from an Ole Mass (traditional Carnival) character. Local Rastas sometimes maintain they themselves must be crazy, or alternatively, if everyone else says they are, then it is everyone else who should be in St Ann's. For they

regard the establishment as 'mad': 'When the Whites got their share of learning, they take it and do a whole heap of things and most of all they want to destroy mankind'.

To term political figures 'mad' is common picong. Dr. Eric Williams, the first prime minister of independent Trinidad, succeeded another politician known as the 'Mad Scientist'. 'The Doc' himself was popularly regarded as mad, sometimes in all seriousness. His elusive *social* persona, an ex-Oxford scholar, aloof yet with an apparently incisive understanding of the masses, his gradual withdrawal from public life behind his dark glasses and hearing aid, the uncertain number of his marriages, and his intelligence, all argued he had studied too hard. After his death, articles in the press suggested that he had been clinically mad: 'You can't reach him . . . He always come one better.'[26] The Doc's madness was eccentric or *high*, with connotations of studiation madness and even of European *high science* (magic). *High mind* can become a type of vice and renders one vulnerable through one's caprices; it becomes real madness if it take one over unchecked. The converse, that all madness necessarily entails a special type of wisdom, is not held: 'There ai' no sense in madness, it just stupidness'. The expression 'method in madness' simply implies feigned madness in Trinidad (not a higher sanity as it may in Britain) and was once suspected by plantation owners as a popular way to avoid estate work.[27]

## Conclusion

The arbitrary eruptions of madness do not escape social meaning. If madness usually represents a discrete and easily recognisable state, it also provides in practice a rich and *according* term for other, more ambiguous behaviours, and an image to describe those who are 'too clever' or antisocial to join in daily concerns. Even in the 'strong' sense, madness recalls the demotic values of reputation; the bush as opposed to the town; Creole rather than English; *outside* rather than *inside*; the vices of obeah, ganja and excessive drunkenness. The ultimate image of the worthless man, of vice carried to its logical and inexorable conclusion, of unsocialised nature, is the madman. If tabanka and studiation madness can be interpreted, as I have done, as ironic commentaries on selfish and pretentious attempts to imitate colonial and European life when this is not 'according to circumstance', vices warn of the opposite danger – that of abandoning *social* life altogether. Tabanka may be read as the over-valuing of respectability as a practical goal, while vice is its undervaluing. Failures of balancing interests against possibilities they both

lead to madness, the caricature of the impoverished and *worthless* Black. Neither are simply 'indigenous' explanations of sickness, independent of external constraints. Both are rooted in the colonial and economic history of the West Indies, in the inescapable irony of being poised between two ascribed sets of values, one derided as worthless, the other only precariously attainable.

## Notes

1. Part of this material was published in *Pathology and Identity: The Work of Mother Earth in Trinidad* (Cambridge: 1993) and 'Psychiatry's Culture', *International Journal of Social Psychiatry*, 42 (1996) 245–68.
2. D. Bhugra, and R. Littlewood (eds), *Colonialism and Psychiatry* (Delhi: 2001).
3. J. McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: 1995).
4. See, B.J.F. Laubscher, *Sex, Custom and Psychopathology: A Study of South Africa Pagan Natives* (London: 1937); G. Tooth, *Studies in Mental Illness in the Gold Coast* (London: 1950); J.C. Carothers, *The African Mind in Health and Disease* (Geneva: 1953).
5. F.D. Lugard, *The Dual Mandate in British Tropical Africa* (Edinburgh: 1929); W. Ernst, *Mad Tales From the Raj: The European Insane in British India* (London: 1991).
6. G. Tooth, *Studies in Mental Illness in the Gold Coast* (London: 1950).
7. O. Mannoni, *Psychologie de la Colonisation* (Paris: 1950).
8. J. McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: 1995).
9. L. Mars, *La Lutte Contre La Folie* (Port-au-Prince: 1946); F. Fanon, *Peau Noir, Masques Blanches* (Paris: 1952).
10. P.A. Taguiett, *La Force du Prejugé: Essais sur le Racism et ses Doubles* (Paris: 1988); M.A. Osborne, *Nature, the Exotic and the Science of French Colonialism* (Bloomington: 1994).
11. J. Goody, *The Expansive Moment: Anthropology in Britain and Africa 1918–1970* (Cambridge: 1995).
12. M. Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940* (Cambridge: 1992).
13. R. Littlewood, 'Jungle madness', *International Journal of Social Psychiatry*, 31 (1985) 194–197; W. Ernst, *Mad Tales From the Raj: The European Insane in British India* (London: 1991).
14. A. Brigham, *Remarks on the Influence of Mental Cultivation upon Health* (Hartford, NY: 1882).
15. B. Rush, 'Observations intended to favour a supposition that the black colour (as it is called) of the Negroes is derived from the Leprosy', *Transactions of the American Philosophical Society*, 4 (1799) 289–297.
16. The exception is Kenya. See, J.C. Carothers, *The African Mind in Health and Disease* (Geneva: 1953).
17. L.E. Fisher, *Colonial Madness: Mental Health in the Barbadian Social Order* (New Brunswick: 1985).
18. Ibid.

19. Barry Chevannes, a Jamaican anthropologist, has argued that Rasta dreads were initially an imitation of derelicts or the mad in 1950s Kingston. See, B. Chevannes, 'The phallus and the outcast', in B. Chevannes, *Rastafari and Other African Caribbean Worldviews* (London: 1995).
20. P. Wilson, *Crab Antics: The Social Anthropology of English speaking Negro Societies of the Caribbean* (New Haven: 1973).
21. K. Warner, *The Trinidad Calypso* (London: 1982), p. 96.
22. H. Rodman, *Lower-Class Families: The Culture of Poverty in Negro Trinidad* (New York: 1971), p. 217.
23. K. Warner, *The Trinidad Calypso* (London: 1982), p. 102; H. Rodman, *Lower-Class Families: The Culture of Poverty in Negro Trinidad* (New York: 1971), p. 214.
24. Ibid.
25. D. Lowenthal, *West Indian Societies* (Oxford: 1972), p. 141.
26. The Enemy, 'Was Dr. Williams mental?' *The Bomb* (Port-of-Spain), 1 May 1981.
27. G. Lewis, *Main Currents in Caribbean Thought: The Historical Evolution of Caribbean Society in its Ideological Aspects, 1492–1900* (Kingston: 1983), p. 178.

# Index


Africans
  biological arguments, 57
  and break-down of systems, 51–2
  as criminal lunatics, 58–9
  and culture-contact, 48
  detribalization of, 52–3
  and education/training, 45
  instability of, 59
  and neurological disease, 58
  and presence/absence of European style disorders, 53–5
  psychology of, 47
  size/capacity of brains, 46–7
  and social movements/processes, 56
  traditional healing practices, 13
  *see also* North Africans; West Africans
*Algérie Médicale*, 26
Algiers School, 6–8, 10, 201
  authority of, 31, 35
  critics of, 31–2
  and ECT, 29, 34
  geographic, political, professional contexts, 32–3
  hegemony of, 32
  and increased contact with indigenous peoples, 22, 27
  and new therapies, 27–9
  origins, 18–19
  and patients, 33–4
  and primitivism, 24–7
  as pseudo-scientific support system, 18
  and psychosurgery, 29–31
  publications from, 26–7, 31
  rise of, 34–5
  and sexual behaviour, 26
  success of hospital system, 22
  and use of somatic treatment, 27–31
Ali, Mohamad, 142
American Indians, 51
American Psychiatric Association, 85
Andreas-Salome, Lou, 127
*Annales Médico-Psychologiques*, 23, 26
*Anthropologie*, 49
anthropology
  and colonial physicians/administrators, 48
  critiques of, 49–50
  and culture-contact, 50
  and detribalization, 50–3
  and disappearance of 'raw native', 50–1, 53
  evolutionary theories, 51
  and fieldwork, 48–9
  link with psychiatry, 48–9
  and training, 49
Apituley, J.J.D., 183
Arrii, Don Côme, 27
Association for Indies Physicians, 179, 183
Association for Indonesian Physicians, 183
Aubin, Dr. Henri, 30, 31, 204
Augustin, P.L., 183
*Autobiography* (Nehru), 139

Ballantyne, Tony, 102
Bardenat, Charles, 34
Baruk, Dr. Henri, 28, 30
Bastide, Roger, 205
Beard, George, 54
Bergson, Henri, 19
Berkeley-Hill, Owen, 127, 135
Besant, Annie, 140
Bicêtre, 18
*Black Death, White Medicine* (Echenberg), 198
Bleicher, Maria, 85–6, 88, 89
Bose, Girindrashekhar, 12, 126–30, 135–8, 145–6
British Eugenics Society, 44
British Medical Association, 44
*British Medical Journal*, 41

British Medico-Psychological Association, 73, 74, 78
Budi Utomo, 179
Busfield, Joan, 111
Bynum, W.F., 58

Carnegie Corporation, 44
Carothers, J.C., 45, 46, 48, 53, 59
Cassidy, Dr., 75
Cazanove, Dr., 204
Centre Georges Devereux, 211–12
Cerletti, Ugo, 28
Ceylon
  government action in, 156–7
  inadequacy of psychiatric provision, 155–6
  Mapother's visit to/observations on, 155–62
Ceylon asylums
  availability of treatment, 158
  expenditure on, 158
  institutional aspects, 159–60
  and legal reform, 159
  overcrowding in, 157–8
  and patient admissions, 160
  and psychiatry-neurology link, 161
  recommendations, 159–62
  recreational aspects, 159–60
  running of, 160–1
  staffing of, 161–2
Chabane, Mohamed, 212
Chakrabarty, Dipesh, 129
Charcot, Jean Marie, 211
Charcot, Jean-Martin, 19
Chatterjee, Partha, 138–9
civilization, 2, 23, 25, 48, 49, 53–5, 60
*Civilization and its Discontents* (Freud), 133, 134
Collignon, René, 204
Collomb, Dr. Henri, 9, 202–10
colonial psychiatrists
  ambitions, 2, 6–9
  influence/contribution of, 2–3, 14–15, 35
  and post-colonial difference, 3
  variations between theories/practices of, 3
colonial psychiatry
  as benefit of imperialism, 154
  and Freud, 129–30
  gendered, 99, 111–13
  identification of mad subjects, 100–1
  and ignoring/dismissing local beliefs/practices, 198
  insular nature of knowledge, 42
  limited reach of, 68
  link with social anthropology/psychology, 56–9
  and need for special accommodation, 101
  as poorly represented, 41
  and process of 'othering', 42
  stereotypes, 106–11
  and training of physicians, 42
  transition to post-colonial, 197
Colonial Social Science Research Council (CSSRC), 56
colonialism
  and educability of African subjects, 43–4
  in Fiji, 102
  and practice of anthropology/ethnographic writing, 48
  rule as kind of madness, 1–2
  and white superiority, 189–90
colonized subjects
  and maladjustment to modernity/civilization, 2
  meaningful articulations of patients, 2
  normality baseline, 2
*A Concept of Repression* (Bose), 131
Congress of French and Francophone Alienists and Neurologists, 19, 27, 33
Conry, Dr., 76
*Console and Classify* (Goldstein), 210
culture, 9–11
  clash of, 48–51

Dakar School, *see* Fann Hospital (Dakar)
Darwinism, 24
Das, Veena, 91
Davar, Bhargavi V., 137–8
*De Taak* (The Task) journal, 181–3

Delay, Jean, 34, 35
Deniker, Pierre, 34, 35
Des Voeux, Sir George, 101
Devos, Anne, 211
*Diagnostic and Statistical Manual III* (DSM III), 205
Dingwall, Robert, 68
Diop, Dr. Babakar, 204, 211
Diouff, Mamdou, 198
Dodds, Dr. William John, 4, 70, 71, 72, 73, 74, 83
Dunstan, John Thomas, 78
Dupouy, Roger, 20
Dutch colonial psychiatry
  and data collection, 184
  and deceptive nature of Indonesians, 187
  and inability to speak local language, 184
  and indigenous mind, 173–90
  and interactions affected by power differences, 184–5
  and need for scientific understanding, 187–8
  and Orientalist assumptions, 186–7
  and papers given to the PEB, 172–3
  and political motivations, 183–4
  and politics/psychology mix 174–7
  protests against, 173–4, 179
  and psyche of the Malay, 177–9
  and questioning of assumptions by, 185–6
  reactions to papers, 179–88
  and viability of comparisons, 186
Dutch colonialism, 173

*East African Medical Journal* (EAMJ), 43, 46
East African School, 8, 11
  and anthropology/clash of cultures, 48–51, 59
  and challenging physical presence of blacks, 60
  and civilization/mental disease, 53–5, 60
  and difference, 55–6
  emergence of, 41–2
  and governance, 60
  and psychology of detribalized native, 51–3, 59
  and rise of scientific disciplines, 45–8
  and tropicalization of scientific disciplines, 56–9
Echenberg, Myron, 198
electro-convulsive therapy (ECT), 8, 28–9, 115
epilepsy, 28, 33
ethnicity
  and gender/poverty link, 104–5
  and indigenous mind, 174–5, 177, 180–1
  and patient admissions, 104
ethnography, 221
ethnopsychiatry, 30–1, 42, 197
eugenics, 46

Fann Hospital (Dakar), 9, 199, 202–13
Fanon, Frantz, 1–2, 7, 11, 14, 18
Fassin, Didier, 209
Fiji, 99–100
  asylums in, 100–3
  British colonialism in, 100, 102
  and colonial interventions, 116–18
  economic hardships, 102
  financial resources, 101–2
Firth, Raymond, 56
Flood, J.E.W., 47
Floyd, Dr. Virginia, 210
Ford Foundation, 209
Fort Beaufort asylum (South Africa), 71–2, 75–7
Foucault, Michel, 3, 67, 69, 70, 91, 100, 139–40
French psychiatry
  and culture/civilization relationship, 23, 25
  effect of Muslim immigration on mental hygiene, 27
  encroachment of psychologists/philosophers, 19
  as metropolitan affair, 17
  model establishments, 22
  new ideas in, 24–5
  origins, 17–18
  and patient-primitive comparison, 24–6

French psychiatry – *continued*
and primitive mentality, 23–7
and program for 'open services', 20–2
and race, climate, madness relationship, 22–4
reaction of French Senate to, 21
reform of discipline, 19–21
in the Maghreb, 19, 21–2
and use of psychosurgery, 30
Freud, Sigmund, 12, 24–5, 124, 127–8, 129, 130–6, 145
*The Future of an Illusion* (Freud), 132–3, 142

Gandhi, Mahatma, 140–1, 143–5, 183
Gay, P., 134
Gbodossou, Dr. Erick, 204, 210
gender, 5
colonial interventions, 116–18
colonial stereotypes, 106–11
and control/care of the body, 113–16
ethnicity/poverty link, 104–5
indigenous mind compared to, 176, 177
and invasive treatments, 115
and madness, 100, 104, 105–6, 108
multiple/hierarchical locations, 103–4
and occupational therapy, 116
and puerperal insanity, 111–13
and women's insanity, emotions, reproductive lives, 106–11, 112–13
and work roles, 108–9
Gennep, Arnold van, 173, 176, 181
Gilks, John, 44
Gilman, Sander, 48
Gluckman, Dr. Henry, 80
Goldstein, Jan, 210
Goody, Jack, 49
Gordon, H.L., 41, 43–9, 52, 57, 58
governance, 9–11, 60
Grahamstown asylum (Fort England) (South Africa), 71
Greenlees, T.D., 71
Griaule, Marcel, 204
Gueye, Dr. Momar, 211, 213
Gunasekara, Dr. S.T., 153–4

Haddon, A.C., 47
Hartnack, Christane, 129
Hatta, Mohammad, 188–90
Hesnard, Angelo, 201
*Hindu–Muslim Unity* (Berkeley-Hill), 135
Hobley, C.W., 54
Hôpital Général, 18
Hutton, P.W., 58
Hyslop, Dr., 73

Indian asylums
damning assessment of, 164–5
funding, 164–5
and lack of leadership, 165–6
and legal changes, 167
Mapother's visits to, 157, 163–7
model institution at Mysore, 166
mortality in, 165
observations on, 163–7
and programme of survey/public information, 167
*The Indian Journal of Psychology*, 126, 134
Indian Medical Service (IMS), 155
Indian psychoanalysis
agenda, 130–8
and autobiography, 140, 141
critical attitude toward theory, 131–2
and free association, 132
and Freud, 130–6
and Jung, 134
locating/positioning of, 136
and Nehru, 138–46
and opposing set of wishes, 131–2
origins/development, 125–30
professional bodies, 126–8
reflexive process, 145
and religion, 132–3, 135–8
and science, 137, 141
and self, 138–40, 141–2
and simplistic ideas, 134
sociality of, 129
and transformative moment, 135
university courses in, 126

Indian Psychoanalytic Society, 127–8, 135, 137
Indian Psychological Association, 126–7, 129, 134
Indian Science Congress, 133, 157, 163
Indigenous Knowledge Project, 209
indigenous mind
  as childlike, 175, 178, 182, 184, 185
  and colonial administration, 175–6
  and emotional events, 174, 175
  initial/sustained critiques of views on, 180–8
  and lack of depression/melancholia, 178
  and Malay psyche, 177–9
  male/female metaphor, 176, 177
  maturity of, 16
  and need for freedom, 181
  and need for guidance, 176, 179
  observations on, 174–9
  racial/ethnic differences, 174–5, 177, 180–1
  scientific understanding of, 176, 180, 187–8
  and sexual impulses, 178
  slowness/laziness of, 178
  and suggested repressive measures, 175–6
  as suggestible, 178
  and superstition, 178
*Indisch Genootschap* (Indies Society), 177
Indonesian Medical Association, 179
*Indonesische Vereeniging* (Indonesian Society), 183
*International Classification of Diseases* (ICD), 205
International Institute of African Languages and Cultures (IIALC), 49, 51
*International Journal of Psychoanalysis*, 132
International Psychoanalytic Association, 126, 129
Islam, 7, 208
Iyer, Subramanya, 134

Jones, Ernest, 127
Jung, Carl, 132, 133–4

Kakar, Sudhir, 138–9
*Kemadjoean Hindia* (Indies Progress), 181
*Kenya Medical Journal*, 42–3
Khilnani, Sunil, 139
Kleinman, Arthur, 91
Kraepelin, Emil, 10, 19, 55, 174–5
Kurtz, Conrad, 24

*La Folie au Sénégal* (Diouff & MBodj), 198
*La Sorcellerie au Maroc* (Mauchamp), 199
Labouret, Henri, 199
Lambert, H.E., 52
Lambo, Dr. Thomas A., 205
Lapipe, Dr., 28, 29
*Latah* syndrome, 54–5
Latumeten, J.A., 183, 187–8
Lawang mental hospital, 172, 174
Lebou, 198
Lebovici, Serge, 212
*L'Encéphale*, 28
Lévy-Bruhl, Lucien, 24, 52
*L'Oedipe Africain* (Ortigues), 204, 207
London County Asylum, 153
Louis XIV, 17–18
Lugard, Frederick, 49
Lyautey, Marshal Hubert, 33

McCulloch, Jock, 42, 47
MacGregor, Sir William, 102
madness
  as all or nothing condition, 224
  arbitrary eruptions of 232
  and colonialism, 1–2
  and gender, 100, 104, 105–6, 108
  identification of, 100–1
  link with race/climate, 22–4, 27
  local meanings/manifestations, 221–5
  as male characteristic, 223–4
  redefinition of, 23
  studiation, 224–5
  in Trinidad, 221–32

madness – *continued*
  weak, 230–2
  West African view, 198–9
Mair, Lucy, 49–50
Majeed, Javed, 136
Makerere Medical School, 44
Malan, Dr. D.F., 90
Malinowski, Bronislaw, 48, 50–1, 221
Mapother, Edward, 6
  account of visit to Ceylon, 155–7
  in India, 157, 163–7
  interpretation of travels, 168
  invited to Ceylon, 153–4
  observations of, 168–9
  reports, 157–62
Maréschal, Pierre, 29, 34
Martin, Gustave, 200
Mathari Mental Hospital (Nairobi), 41, 45, 58
Mauchamp, Dr. Emile, 199
Maudsley Hospital (London), 6, 153
MBodj, Mohamed, 198
medical training, 43–4
Meduna, Ladislaz, 27
mental disorders
  and African educability, 44–5
  and biological difference, 24
  and boundary disputes, 19
  and civilization, 53–5
  and dangers of colonial territories, 23–4
  and doctor–patient relationship, 19
  entering into minds of, 69
  as hereditary–degenerative, 19
  link with tropical disease, defectiveness, primitivism, 44
  and move from asylum to hospital, 20–1
  new classification of, 19
  nursing care for, 68
  and patient care, 20
  and redefinition of madness, 23
  relationship with civilization, 48, 49
  and savage/neurotic mentalities, 24–5
  and segregation of mentally ill 20
  settling of, 99, 113–16
  transitional moment, 19–20
Mental Hospitals Departmental Committee (South Africa, 1937), 79
Mental Hygiene and Prophylaxis League, 20
mental nursing, 68, 69
  as arduous/exacting, 75
  as careless/unreliable, 76–7
  coloured staff, 72, 76–7, 83
  conditions of work, 79–80, 83–4
  difficulties of recruitment, 73
  effect of Depression on, 78–9
  gender issues, 75, 78–9, 80–1, 89
  impact on patients, 76–7, 79–80, 84–91
  importing from overseas, 73–4, 75
  inclination/aptitude of, 74
  and lack of resources, 78
  and moral management, 91
  optimism concerning, 77–8
  and patient behaviour, 75–6
  power/control, 84–91
  qualifications/calibre of, 72, 74, 77, 81, 82–3
  racism in, 87, 88
  records of personnel, 69–70
  shortages, 72, 76, 80, 81–4
  and surveillance of patients, 70
  turnover of, 74–5
  wages for, 74–5
  white staff, 72–6, 80–3, 89
  working/lower-middle class attendants, 74
Mitra, Panchan, 134
Mitra, Suhrit Chandra, 131
Moniz, Egas, 30
Monteil, Charles, 199
Moreau de Tours, Jacques-Joseph, 23
Moro, Marie Rose, 212
mortality rates, 5, 104–5, 113, 165
Mulago Mental Hospital (Uganda), 58

Nandy, Ashis, 128
Nathan, Tobi, 212
Ndoye, Omar, 211
Nehru, Pandit, 139–46
Nigeria, 205
North Africans, 201

Oliver, R.A.C., 44
Ortigues, Edmond, 203, 207
Ortigues, Marie-Cécile, 203, 207, 212

Parle, Julie, 68
Pasteur Institut (Brazzaville), 200
Pienaar Inquiry (1923), 89
Pinel, Philippe, 18
*Politiek-Economischen Bond* (PEB; Political-Economical Union), 83, 172–3, 176–7, 180, 181, 190
Porot, Dr. Antoine, 18, 20–1, 22, 25–6, 31, 34, 201
Porot, Dr. Maurice, 29, 30, 31, 32, 35
Port Alfred asylum (South Africa), 71
Promotion de la Médécine Traditionelle (Prometra), 209–10
psychiatric fascism, 12, 181–2
psychiatry
  and answering back, 11–15
  colonial, 33
  cultural, 220
  and difference, 55–6
  English–French difference, 220–1
  and imperialism, 220
  institutions, 3–6
  and physical symptoms, 57–8
  pioneers in, 18
  productive cores/stultified peripheries, 17
  and race, climate, madness link, 22–3, 57
  and social engineering, 18
  somatic interventions, 27–9
  in South Asia, 154–5
  and tropical invalid 57
  United States model, 221
psychoanalysis, 12–13, 124–5
  Indian agenda for, 130–8
  and neurosis of self, 131
  and religion/atheism, 131
psychology
  and colonisation, 188–90
  cultural aspects, 130
*The Psychology of Mau Mau* (Carothers), 59
*Psychopathologie Africaine* journal, 204, 210
psychosurgery, 8, 29–31, 30
psychotropic drugs, 4, 6, 69, 115

Rabain, Jacqueline, 204
racism, 9–11
  and psychic damage, 1
  and racial difference, 45, 46–7
  and treatment of Jewish patients, 87, 88
Rafferty, Anne Marie, 68
Raper, Alan, 45–6
Reboul, Henri, 201
Régis, Emmanuel, 201
religion, 132–3, 135–8
Rhodes-Livingstone Institute, 56
Rich, Paul, 48
Richards, Audrey, 50
Ringenbach, Dr., 200
Robben Island, 71–2
Rockefeller Foundation, 154, 162
Rondepierre, Dr., 28, 29
Rose, Jacqueline, 124
Rouch, Jean, 205
Russell, Dr. William, 78

Said, Edward, 186
St Giles hospital (Fiji), 99
  admission/outcome patterns, 104–5, 117
  and controlling the body to settle the mind, 113–16, 118
  gendered discourse/madness link, 105–6
  gendered space/infrastructure in, 103–4
  and medicalisation of sexuality, 111–13
  moral/humane care in, 113–14
  mortality rates, 104–5, 113
Sakel, Manfred, 28
Sartorious, Norman, 205
schizophrenia, 27–8, 33, 34–5
science, 13
  and entrepreneurial spirit, 17
  relationship with imperialism, 17
Scientific Council for Africa South of the Sahara, 205
Scott, H.S., 45
Seal, Brojendra Nath, 126

Searle, Charlotte, 81–2
Select Committee on the Treatment of Lunatics (South Africa, 1913), 80
Seligman, C.G., 53
Seligman error, 53
Senegal, 197–8, 210–11, 221
Senghor, Léopold Sédar, 13, 202–3
Sengupta, N.N., 126, 130
*Sinar Hindia* (Indies Ray), 181
Sircar, Mahendra Lal, 125–6
Sitanala, J.B., 183
slavery, 14
South African Medical Council, 78
South African Nursing Association, 80–1
South African Nursing Council (SANC), 81, 83–4
*South African Nursing Record*, 70
South African Trained Nurses Association, 77
South Asia, 154–5, 168
Stanton, Sir T., 47
Storper-Perez, Danielle, 208
STOVIA, 173, 177, 179, 183, 187
studiation, 14, 224–5
Sudirohusodo, Wahidin, 179
*Suggestions for a New Theory of Emotions* (Mitra), 131
Sukarno, Dr. Achmad, 188–9
Sutter, Jean, 26
Swartz, Sally, 90

tabanka, 14, 227–30
te Water, J., 72–3
Theosophical Society, 140–1
Thomson, M.G., 73, 77–8, 89
Tooth, Geoffrey, 56
Toulouse, Edouard, 20, 21
transcultural psychiatry, 9, 197–8, 205–13
Travaglino, Dr. Petrus Henri Marie, 10, 172, 174–7, 179, 180, 182–3, 184–7
Travélé, Moussa, 199
Trinidad
  and gender/class, 225–6
  and good training, 226
  local notions of mental illness, 221–5
  and reputation, 225–6
  and respectability, 226
  and tabanka, 227–30
  and thieving, 231
  and vice, 230–1
  vices/weak madness, 230–2
Trowell, H.C., 44
Tuke, Samuel, 70
Tuke, William, 70
*Tunisie Médicale*, 26

University of Dakar, 197, 202

Valantin, Simone, 204
Valkenberg Mental Hospital (South Africa), 69
  adjoining site for coloured patients, 71–2
  affect of Depression on, 78–9
  conditions at, 83–4
  construction of, 70–1
  designed for white population, 70–1
  difficulties experienced in, 72
  and employment of coloureds, 72, 76–7
  and employment of white staff, 72–6, 80–3, 89
  overcrowding in, 72, 78, 79–80, 83
  patient experiences, 70, 84–91
van Loon, Feico Herman, 177–9, 180–1, 183–7
Vaughan, Megan, 42
Vint, F.W., 41, 44, 46, 47
Vos, Pieter de, 84

Webster, Charles, 68
West Africans
  and aggression, 198
  exposure of French psychiatrists to mentally-ill, 201
  and imposition of Western medical knowledge, 198
  internment/transportation of, 200
  invisibility of mental illness, 199–200
  and local healers, 198–9

post-colonial practice, 202–13
and spirituality, magic, medicine link 199;
view of madness, 198–9
and working with traditional healers, 202–13
West Indies, *see* Trinidad
Wilson, Peter, 226
Wirjosandjojo, Sukiman, 183
World Bank, 198, 209
World Federation for Mental Health, 205
World Health Organization (WHO), 13, 197, 205, 208–9

Yacine, Kateb, 34

Zempleni, Andras, 203